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IN THE SUPREME COURT OF THE STATE OF NEVADA

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KIMBERLY KLINE,

Appellant,

vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO., ESQ., Sr. Appeals Officer; RAJINDER NIELSEN, ESQ., Appeals Officer; ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

Supreme Court No. 82608

Injured Worker Appellant's Appeal of the

Second Judicial District Court,

The Honorable Connie Steinheimer's Order

of the Appeals Officer's Decision of the Department of Administration

APPELLANT'S APPENDIX

Volume I

Pages 0001- 0250

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ALPHABETICAL INDEX

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AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby certify that the preceding documents, ***APPELLANT'S APPENDIX VOLUMES I - IX***, filed in Supreme Court case number 82608, do not contain the social security number of any person.

DATED this 18 day of January, 2022.

THE LAW FIRM OF HERB SANTOS, JR.
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By _____

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IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERBVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO, ESQ., Sr. Appeals Officer; RAJINDER NIELSEN, ESQ., Appeals Officer, ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

CASE NO.: CV19-01683

DEPT. NO.: 4

ORDER DENYING PETITION FOR JUDICIAL REVIEW

On August 28, 2019, Petitioner KIMBERLY KLINE, by and through her attorney, Herb Santos, Jr., Esq. of the Law Firm of Herb Santos, Jr., filed a *Petition for Judicial Review*. On September 9, 2019, Respondent the CITY OF RENO and CANNON COCHRAN MANAGEMENT SERVICES, INC. (hereinafter "CCMSI"), by and through their attorney, Timothy E. Rowe, Esq. and Lisa Wiltshire Alstead, Esq. of McDonald Carano LLP, filed a *Statement of Intent to Participate*.

On September 18, 2019, Rajinder K. Rai-Nielsen, Esq., Appeals Officer, filed a *Certification of Transmittal*. Also, on September 18, 2019, the *Record on Appeal in Accordance with the Nevada Administrative Procedure Act (Chapter 233B of NRS)* and a *Transmittal of Record on Appeal* ("ROA") were filed.

On October 16, 2019, an *Order for Briefing Schedule* was entered setting forth the briefing deadlines pursuant to NRS 233B.130.

On October 28, 2019, Petitioner KIMBERLY KLINE and Respondent CITY OF RENO and CCMSI filed a *Stipulation to Extend Time to File Briefs* wherein the parties stipulated and agreed to extend the deadline to file Petitioner's opening brief to December 15, 2019, and Respondent's answering brief to January 20, 2020.

On November 4, 2019, an *Amended Briefing Schedule Order* was entered extending the briefing deadlines in accordance with the October 28, 2019 stipulation. On November 7, 2019, Petitioner KIMBERLY KLINE filed a *Notice of Entry of Order*.

On December 12, 2019, Petitioner KIMBERLY KLINE and Respondent CITY OF RENO and CCMSI filed a second *Stipulation to Extend Time to File Briefs* wherein the parties stipulated and agreed to extend the deadline to file Petitioner's opening brief to January 14, 2020, and Respondent's answering brief to February 14, 2020.

On December 20, 2019, an *Order* granting stipulation to extend time periods set forth in NRS 233B.133 was entered extending the briefing deadlines in accordance with the December 12, 2019 second stipulation. On January 9, 2020, KIMBERLY KLINE filed *Notice of Entry of Order*.

On January 13, 2020, Petitioner KIMBERLY KLINE and Respondent CITY OF RENO and CCMSI filed a third *Stipulation to Extend Time to File Briefs* wherein the parties stipulated and agreed to extend the deadline to file Petitioner's opening brief to February 24, 2020 and Respondent's answering brief to March 24, 2020.

On January 16, 2020, an *Order Granting Stipulation to Extend Deadlines* was entered extending the briefing deadlines in accordance with the January 13, 2020 third stipulation. On January 21, 2020, Petitioner KIMBERLY KLINE filed a *Notice of Entry of Order*.

On February 24, 2020, KIMBERLY KLINE filed *Petitioner's Opening Brief*.

On March 20, 2020, Petitioner KIMBERLY KLINE and Respondent CITY OF RENO and CCMSI filed a fourth *Stipulation to Extend Briefing Deadlines* wherein the parties stipulated and agreed to extend the deadline for Respondent's answering brief to April 23, 2020 and Petitioner's reply brief to May 23, 2020.

On March 23, 2020, a *Second Amended Briefing Schedule Order* was entered extending the deadline for Respondent's answering brief to April 23, 2020 and Petitioner's reply brief to May 23, 2020 pursuant to the parties' stipulation.

On April 23, 2020, the CITY OF RENO filed *Respondent's Answering Brief.* On May 22, 2020, KIMBERLY KLINE filed *Petitioner's Reply Brief.* Thereafter, the parties' briefs were submitted to the Court for consideration.

Also, on May 22, 2020, Petitioner KIMBERLY KLINE filed a *Request for Oral Argument* on the Petition for Judicial Review. On May 27, 2020, CITY OF RENO also filed *Request for Oral Argument* on KIMBERLY KLINE's Petition for Judicial Review. Therefore, on June 17, 2020, the Court found that it would be an appropriate exercise of discretion by the Court to allow for oral arguments on the Petition for Judicial Review and entered *Order to Set.*

On June 26, 2020, the parties filed *Application for Setting,* wherein the parties agreed to a telephonic hearing to be conducted on September 2, 2020. On September 2, 2020, the parties filed a second *Application for Setting*, wherein the parties agree to vacate the September 2, 2020 hearing and reset the hearing for September 30, 2020. On October 5, 2020, the parties filed a third *Application for Setting*, wherein the parties agreed to reset the oral arguments on the Petition for Judicial review to November 2, 2020. On November 2, 2020, the parties filed a fourth *Application for Setting,* wherein the parties vacated the November 2, 2020 hearing, and reset it for November 19, 2020.

On November 19, 2020, the Court heard oral argument on KIMBERLY KLINE'S Petition for Judicial Review via simultaneous audio-visual transmission pursuant to Supreme Court Rules Part IX due to the courthouse's closure in light of the COVID-19 pandemic. At the hearing, Herb Santos, Jr., Esq. argued on behalf of Petitioner KIMBERLY KLINE, who was present for the hearing via simultaneous audio-visual transmission from Washoe County, Nevada. The opposition was argued by Lisa Alstead, Esq., on behalf of the CITY OF RENO. After the hearing, the transcript of the proceeding was submitted to the Court on December 1, 2020. Thereafter, the matter was taken under advisement by the Court.

KIMBERLY KLINE's Petition for Judicial Review arises from a June 25, 2015 industrial injury KLINE suffered when her work vehicle was rear-ended by another vehicle. (ROA 177-182,

395). The June 25, 2015 accident (subject incident) was her second motor vehicle accident within a month. (ROA 409). The first occurred on June 3, 2015 and KLINE's injuries sustained therein were nearly resolved at the time of the second incident. (Id.). On June 25, 2015, following the subject incident, KLINE went to St. Mary's and received medical treatment for back and neck pain. (ROA 182-185, 409-411). KLINE was diagnosed by Dr. Richard Law with an acute lumbar radiculopathy, sprain of the lumbar spine, and acute pain in the lower back. (ROA 410).

On July 23, 2015, the claim was accepted for cervical strain. (ROA 453). KLINE received medical treatment from Dr. Scott Hall, M.D., in addition to chiropractic care and physical therapy. (See generally ROA 296-341). On October 28, 2015, KLINE was determined to be at maximum medical improvement ("MMI"), stable not ratable, and was released to her full duty with no restrictions. (ROA 490). On November 6, 2015, CITY OF RENO issued a notice of intent to close KLINE's claim. (ROA 295). After an appeal, the Department of Administration concluded that KLINE's industrial claim was closed prematurely. (ROA 239-240).

On January 13, 2016, KLINE saw Dr. Hansen for chiropractic care for her neck pain and Dr. Hansen assessed that KLINE had "cervical disc displacement, unspecified cervical region." (ROA 296-298). Dr. Hansen felt that there was a high probability within a medical degree of certainty that KLINE's injuries were related to the rear-end collision she had recently sustained. (ROA 298, 306, 339). Also, on January 13, 2016, KLINE underwent an MRI, which found disc degeneration with large disc protrusions at the C5-6 and C6-7 levels, resulting in complete effacement of CSF from the ventral and dorsal aspects of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia. (ROA 299, 503). On July 5, 2016, upon Dr. Hansen referral, KLINE saw Dr. Sekhon due to KLINE's ongoing complaints. (ROA 241-246).

On January 18, 2017, the Appeals Officer entered a Decision and Order which reversed claim closure without a PPD evaluation or rating and ordered Respondent, CITY OF RENO to rescind claim closure and provide medical treatment recommended by Dr. Sekhon. (ROA 167-176). CITY OF RENO timely appealed the decision to District Court and Petition for Judicial Review ensued. On December 11, 2017, Judge Simons issued an Order denying the Petition for Judicial Review.

(ROA 373-387). Therein, the Court noted that the Appeals Officer gave the opinions of Dr. Hall no weight as it pertained to the scope of the claims, and that Dr. Hall's opinions were inconsistent with the medical evidence. (ROA 384). That decision was not appealed.

While the Petition for Judicial Review was pending at the District Court, on June 12, 2017, KLINE had a cervical spine decompression and fusion surgery. (ROA 244, 252). On September 11, 2017, KLINE was determined to have reached MMI, was ratable, and was released for full duty. (ROA 248-249). A permanent partial disability ("PPD") evaluation was performed by Dr. Russell Anderson and KLINE was found to have a 25% whole person impairment ("WPI") from the cervical spine, with 75% of the impairment apportioned as non-industrial. (ROA 250-256, 563-564). The self-insured Employer's third-party administrator ("TPA") issued a determination letter on December 5, 2017, offering a 6% PPD award. (ROA 362, 568). KLINE appealed, and a second PPD evaluation was ordered and subsequently conducted by Dr. James Jempsa on May 8, 2018. (ROA 605-616). Dr. Jempsa found KLINE to have a 27% WPI with none of the impairment apportioned as non-industrial. (ROA 616-617). Because apportionment was not considered, the TPA sent a follow up request asking Dr. Jempsa to review Dr. Anderson's PPD evaluation and address apportionment. (ROA 1162). On May 18, 2018, Dr. Jempsa provided an Addendum which stated, "You will need to contact Dr. Anderson concerning his rationale for apportionment . . . the Claimant stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. I have not received any medical records prior to the industrial injury . . . it is my opinion that apportionment is not necessary in this case." (ROA 1171).

On May 24, 2018, due to the large discrepancy between the two PPD ratings, a TPA determination letter notified KLINE that the 27% PPD award was to be held in abeyance pending a records review by Dr. Jay Betz. (ROA 1172). Dr. Betz provided his review and agreed with Dr. Anderson's findings on apportionment noting Dr. Anderson's conclusions "are well supported by the medical record, known pathologies, AMA guides, and Nevada Administrative Code." (ROA 1189). After a records review, the TPA sent a determination letter on June 13, 2018, offering KLINE a PPD award of 6% based on an apportionment of 75% of the WPI as non-industrial. (ROA 618). KLINE appealed this determination and on July 19, 2018, after a hearing, a Hearing Officer Decision was

entered reversing the TPA's determination. (ROA 601-603). CITY OF RENO maintained that apportionment is proper in this case and offered the uncontested 6% as a lump sum or in installments, and under NRS 616C.380, stated it will pay the remaining, contested 21% in monthly installments. CITY OF RENO, the employer, appealed and requested a stay. (ROA 007:6-7).

On May 1, 2019, an Appeal Hearing was conducted and on August 20, 2019, the Appeals Officer Decision and Order was filed. KIMBERLY KLINE's August 28, 2019 Petition for Judicial Review seeks reversal of the August 20, 2019 Appeals Officer Decision which addressed the appeals of three separate Hearing Officer Decisions: AO1900471-RKN, AO1902049-RKN, and AO1802418-RKN. KLINE, however, only petitions for judicial review of the issue on appeal in AO1900471-RKN, which was the Hearing Officer Decision, dated July 19, 2018, reversing the TPA's May 24, 2018 and June 13, 2018 determination letters regarding apportionment of KLINE's PPD award. (See Petition, Ex. 1, Decision of the Appeals Officer ("Decision"); ROA 001-022). KLINE argues that the Appeals Officer's August 20, 2019 Decision prejudices substantial rights of the Petitioner; was affected by error of law; was clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; and was arbitrary and capricious based upon an abuse of discretion by the Appeals Officer.

In this Order, this Court will determine: (1) whether the Appeals Officer's August 20, 2019 Decision which reversed the Hearing Officer's Decision dated July 19, 2018, and affirming the underlying determinations, dated May 24, 2018 and June 13, 2018, was the result of reversible error of law; and (2) whether the Appeals Officer's Decision finding that the Petitioner's PPD award must be apportioned 75% as pre-existing is not supported by substantial evidence and results in an abuse of discretion.

"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." *NRS 233B.135(1).* "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." Id. "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."

NRS 233B.135(2). "The court shall not substitute its judgment for that of the agency as to the weight of evidence on a question of fact." *NRS 233B.135(3).* "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."
>
> *NRS 233B.135(3).*

Under the standard of review for appeals, if factual findings of the agency are supported by evidence, they are conclusive and reviewing the court's jurisdiction is confined to questions of law. *NRS 612.530(4); NRS 233B.135;* Whitney v. State, Dep't of Employment Sec., 105 Nev. 810, 812 (1989), citing Nevada Employment Sec. Dep't v. Nacheff, 104 Nev. 347, 349 (1988). On appeal, the District Court reviews questions of law, including the administrative agency's interpretation of statutes, de novo. City of N. Las Vegas v. Warburton, 127 Nev. 682, 686 (2011). Review of an Appeals Officer's decision is limited to determining whether there was substantial evidence in the record to support the Appeals Officer's decision and that the findings and ultimate decisions of the Appeals Officer are not disturbed unless they were clearly erroneous or otherwise amounted to an abuse of discretion. Nevada Indus. Comm'n v. Reese, 93 Nev. 115, 125 (1977); State Indus. Ins. Sys. v. Snapp, 100 Nev. 290, 294 (1984); Stark v. State Indus. Ins. Sys., 111 Nev. 1273, 1275 (1995); State Indus. Ins. Sys. v. Hicks, 100 Nev. 567, 569 (1984), State Indus. Ins. Sys, v. Swinney, 103 Nev. 17, 20 (1987); State Indus. Ins. Sys. v. Christensen, 106 Nev. 85, 88 (1990); Brown v. State Indus. Ins. Sys., 106 Nev. 878, 880 (1990); Maxwell v. State Indus. Ins. Sys., 109 Nev. 327, 331 (1993).

The review of the District Court is confined to the record and the court is precluded from substituting its own judgment for that of the agency as to the weight of the evidence on questions of fact. Nevada Indus. Comm'n v. Williams, 91 Nev. 686, 688 (1975); State Indus. Ins. Sys. v. Swinney, 103 Nev. 17, 19-20 (1987); Palmer v. Del Webb's High Sierra, 108 Nev. 673, 686 (1992). The Court's review is limited to a determination of whether the Appeals Officer acted arbitrarily or capriciously, and where there was substantial evidence to support the decision, the Court cannot

substitute its own judgment for that of the Appeals Officer. Construction Indus. Workers' Comp. Group v. Chalue, 119 Nev. 348, 352 (2003); Meridian Gold Co. V. State, 119 Nev. 630, 633 (2003); State v. Public Employees' Ret. Sys., 120 Nev. 19, 23 (2004).

An "agency's fact-based conclusions of law 'are entitled to deference, and will not be disturbed if they are supported by substantial evidence.'" Law Offices of Barry Levinson, P.C. v. Milko, 124 Nev. 355, 362 (2008). "Substantial evidence exists if a reasonable person could find the evidence adequate to support the agency's conclusion, and [the Court] may not reweigh the evidence or revisit an appeals officer's credibility determination." Id.; *NRS 233B.135(4)*. "While it is true that the district court is free to decide pure legal questions without deference to an agency determination, the agency's conclusions of law, which will necessarily be 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 (1986).

CITY OF RENO contends that the appealed issue is a mixed question of law and fact entitled to deference; a question of law as to whether the Appeals Officer correctly interpreted NRS 616C.490(9) and NAC 616C.490 with respect to apportionment, and of fact, as the Appeals Officer was required to apply the facts to the law. CITY OF RENO argues that KLINE is requesting this Court substitute its opinion for that of the Appeals Officer's as to the application of the evidence to the law and contends that to do so is impermissible.

Petitioner, KIMBERLY KLINE argues that reversal of the Appeals Officer's August 20, 2019 Decision is required because the decision is procedurally deficient and the result of reversible error. KLINE argues that the Appeals Officer committed reversible error in two areas: (1) the Appeals Officer relitigated facts which she previously decided in a prior appeal, and (2) the Appeals Officer did not correctly apply NAC 616C.490 and NRS 616C.490. KLINE also argues that the Appeals Officer's Decision is erroneous in view of the reliable, probative, and substantial evidence on the whole record and results in an abuse of discretion.

KLINE argues that the Appeals Officer's Decision relied on the opinions of Dr. Hall which the Appeals Officer previously determined to be not credible, inconsistent with the medical records, and were not stated within a reasonable degree of medical probability. (ROA 174:8-10). KLINE

argues that since the Appeals Officer gave little or no weight to the opinions of Dr. Hall, it is reasonable to conclude that any subsequent opinion by a rating physician should also be bound by those findings. KLINE argues that the Appeals Officer failed to consider her prior findings and conclusions, therefore her August 20, 2019 Decision is based on faulty information.

KLINE also argues that substantial evidence on the record establishes that she did not have a pre-injury impairment under the AMA Guides, 5th Edition. Specifically, KLINE notes the Appeals Officer previously found that Dr. Hansen stated that there was a high probability within a degree of medical certainty that KLINE's injuries were related to the car accident. (ROA 170:23-28). Dr. Hansen opined that the "MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision." (ROA 306). KLINE asserts that the Appeals Officers found that "substantial evidence supports a finding that the industrial accident aggravated the pre-existing condition and that the resulting conditions was the substantial contributing cause of the resulting condition." (ROA 174:6-8). KLINE argues that apportioning the rating by 75% when it had already been determined that the industrial injury was the substantial contributing factor for the resulting condition is inconsistent with the Appeals Officer's prior decision. Therefore, KLINE asserts that the Appeals Officer committed reversible error of law by re-litigating those facts which she previously decided in a prior appeal.

CITY OF RENO, however, argues that KLINE's argument ignores the fact that the question on appeal in the earlier decision was whether claim closure without a PPD rating was proper. (ROA 167:18-23). CITY OF RENO asserts that Dr. Hansen's statement about KLINE's injuries being related to the car accident, and the Appeals Officer's finding that KLINE had "met her burden of proof with substantial evidence that she is not at maximum medical improvement and needs further treatment" required the claim to remain open. (ROA 174:11-12). Thus, the earlier decision, CITY OF RENO contends, makes no findings as to the propriety of apportionment, as the January 18, 2017 Appeals Officer Decision contemplated a possible future PPD evaluation once KLINE had completed treatment and was determined stable. (ROA 174:18-19).

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CITY OF RENO asserts that in the prior decision the Appeals Officer gave more weight to Dr. Sekhon's and Dr. Hanson's medical opinions, and less weight to Dr. Hall's opinion that KLINE did not suffer a ratable impairment. CITY OF RENO argues that the Appeals Officer's decision to give Dr. Hall's opinion no weight is not binding on future rating physicians, as the prior decision pre-dated the spinal fusion surgery, and the PPD evaluations by Dr. Anderson and Dr. Jempsa, as well as Dr. Betz's records review report and expert testimony, upon which the Appeals Officer specifically relied in reaching the Decision at issue here.

The Appeals Officer also gave Dr. Jempsa's PPD evaluation no weight because there was a large discrepancy in Dr. Jempsa's range of motion findings which made his results questionable as "[i]t is well recognized that patients learn from prior rating experience." (ROA 017:16-17, 018:12-18, 1192). Dr. Jempsa failed to apportion because KLINE stated she had no problems with her neck prior to the industrial injury and because he had received no records prior to the industrial injury on June 25, 2015, which the Appeals Officer found was not required under NAC 616C.490. (ROA 018:3-12). The Appeals Officer concluded that Dr. Jempsa's findings were also questionable because "the medical evidence depicts stenosis, spondylitis, and osteophytes which take years if not decades to form." (ROA 018:12-14).

The Appeals Officer based the decision upholding apportionment primarily on the medical evidence from Dr. Anderson and Dr. Betz, whom she "found to be credible and their opinions given the most weight." (ROA 007:19-20, 013:25-26, 014:1-2). Although Dr. Betz testified that Dr. Hall "was probably correct that the [Claimant] suffered a sprain/strain," and that she did eventually improve "as would be expected with a . . . sprain/strain," Dr. Betz testified that there was not "any significant relationship" between those symptoms and the degenerative disc disease findings on KLINE's MRI results. (ROA 055:11-17, 056:1-2). Dr. Betz testified that the reason it took KLINE seven months to improve from the sprain/strain was because "there was unrecognized underlying multilevel degenerative disc changes." (ROA 055:18-23).

While it is true that Dr. Betz's report notes that Dr. Hall's opinion supports Dr. Anderson's conclusion that KLINE's cervical spine pathologies were primarily degenerative in nature and pre-existing, the Appeals Officer Decision does not rely on Dr. Hall's opinion alone. (ROA 011).

Moreover, regardless of whether Dr. Betz relied on Dr. Hall's opinion, what is at issue here is KLINE's pain and additional treatment related to the pre-existing degenerative condition which began after she had recovered from the industrial sprain/strain and was released by Dr. Hall. Dr. Betz's record review report and extensive expert testimony make clear that he considered all medical reporting and imaging studies in reaching his conclusion that the medical evidence establishes that KLINE had a pre-existing condition. (ROA 011-013).

CITY OF RENO argues that Dr. Betz's opinion incorporating Dr. Hall's opinion and his reliance on Dr. Hall's reporting was not inconsistent with the Appeals Officer's prior decision and that the prior decision does not preclude the Appeals Officer from taking that subsequent medical history and documentation into consideration when reaching decisions. In view of all the medical evidence, much of which did not exist at the time of the prior decision relied on by KLINE, the Appeals Officer properly concluded that KLINE had a pre-existing condition mandating apportionment of impairment under NAC 616C.490. This presents a new question of law not previously addressed by the Appeals Officer and which requires a separate and distinct legal analysis and application of the medical evidence than that performed in the prior decision. Thus, CITY OF RENO argues and the Court finds that the prior decision concluding that the industrial injury aggravated a pre-existing condition under NAC 616C.175(1), makes the present decision upholding apportionment based on substantial medical evidence establishing that KLINE had a pre-existing cervical spine condition consistent with the law of the case. The Court finds the Appeals Officer Decision, dated August 20, 2019, was not the result of reversible error nor an abuse of discretion as the Appeals Officer did not re-litigate facts previously decided in a prior appeal and the Decision is supported by substantial evidence.

KLINE also argues that the Appeals Officer erred by not complying with the mandates of NRS 233B.125. NRS 233B.125 states:

> "A decision or order adverse to a party in a contested case must be in writing or stated in the record. Except as provided in subsection 5 of NRS 233B.121, a final decision must include findings of fact and conclusions of law, separately stated. Findings of fact and decisions must be based upon a preponderance of the evidence. Findings of fact, if set forth in statutory language, must be accompanied by a concise and explicit statement of the underlying facts supporting the findings. If, in accordance with

> agency regulations, a party submitted proposed findings of fact before the commencement of the hearing, the decision must include a ruling upon each proposed finding. Parties must be notified either personally or by certified mail of any decision or order. Upon request a copy of the decision or order must be delivered or mailed forthwith to each party and to the party's attorney of record."

NRS 233B.125.

The Court finds the Appeals Officer decision included findings of fact and conclusions of law, separately stated. In addition, the Court finds the Appeals Officer's findings of fact and decision are based upon a preponderance of evidence, and the Appeals Officer enumerated each of the facts underlying those findings.

In addition, KLINE argues that the Appeals Officer committed reversible error by not correctly apply NRS 616C.490 and NAC 616C.490. KLINE argues that NRS 616C.490 requires that there be evidence that a ratable impairment, as defined by the AMA Guides, existed on the date of the industrial injury for apportionment to occur. KLINE argues there is no prior medical records confirming that there was a ratable impairment, prior residual impairment, and proof of a residual impairment which existed on the date of the industrial injury and that Dr. Jempsa, after reviewing numerous prior records predating KLINE's industrial injury, found apportionment was not appropriate. (ROA 617). KLINE asserts that Dr. Betz conceded that there is no documentation concerning the scope and nature of the impairment which existed before the industrial injury. (ROA 087, 088, 094). Thus, KLINE contends that at the time of the industrial injury, she had a 0% impairment due to any pre-existing condition that she may have had, and therefore, the impairment may not be apportioned.

NRS 616C.490 states: "Except as otherwise provided in subsection 10, if 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 there from the percentage of the previous disability as it existed at the time of the subsequent injury." *NRS 616C.490(9)* [effective through December 31, 2019]; Pub. Agency Comp. Tr. (PACT) v. Blake, 127 Nev. 863, 867 (2011) (holding calculations for prior and subsequent injuries when impairment ratings for those injuries were based on different editions of the applicable guide, be reconciled by first using the current edition of the AMA Guides to determine both the percentage of the entire disability and of the previous disability).

The Nevada Administrative Code provides the procedure for completing apportionment. *See NAC 616C.490.* The Administrative Code requires a precise apportionment to be completed "if a prior evaluation of the percentage of impairment is available and recorded for the pre-existing impairment." *NAC 616C.490(3).* However, the Administrative Code specifically contemplates the situation here, where there is no prior rating evaluation of the pre-existing condition. In such a case, the Administrative Code provides in pertinent part that:

> 4. Except as otherwise provided in subsection 5, . . . 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.

NAC 616C.490(4)-(5).

"If there are preexisting conditions . . . 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." *NAC 616C.490(6).* CITY OF RENO argues that NAC 616C.490 does not require that the documentation of a pre-existing condition predate the industrial injury. In Ransier v. State Industrial Insurance Systems, the Nevada Supreme Court stated that "the clause 'which existed before the industrial injury or the onset of the disease' refers to the impairment and not the document." Ransier v. State Indus. Ins. Sys., 104 Nev. 742, 744 at fn. 1 (1988). Although the reference to this regulation is from the prior version, NAC 616.650(6), the language has remained the same. The Ransier Court held that the Nevada Administrative Code "does not require historical documentation, only 'documentation concerning the scope and nature of the impairment,' which can come, as here, from examination at the time of the second injury." Id. (affirming apportionment was proper where no records or documents existed concerning claimant's prior injury, but where both treating physicians found claimant's two injuries to be distinguishable).

CITY OF RENO also argues that the Appeals Officer correctly interpreted NRS 616C.490 and NAC 616C.490 in finding apportionment does not require that the pre-existing condition be a ratable impairment. Rather, CITY OF RENO argues that the rating physician must look for a prior impairment, shown by medical records post-dating the industrial injury. CITY OF RENO argues that KLINE incorrectly insists that apportionment for a pre-existing disease or condition requires a "ratable" impairment to have existed on the date of the industrial accident. "[W]hen the language of a statute is plain and unambiguous, a court should give that language its ordinary meaning and not go beyond it." Nev. Dep't of Corr. v. York Claims Servs., Inc., 131 Nev. 199, 203 (2015). CITY OF RENO argues that the plain language of NAC 616C.490 simply requires an "impairment" with no requirement that the pre-existing condition or disease be previously rated.

"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." *NAC 616C.490(7)*. Here, the Appeals Officer found "Dr. Betz to be a credible witness and his testimony is given great weight. Dr. Betz's testimony was uncontroverted at [the] hearing and no opposing or contradicting expert witness testimony was provided." (ROA 007:19-21). Based on the records from Dr. Sekhon, who performed KLINE's spinal fusion surgery, in addition to MRI, x-ray records, and historical records and diagnoses, demonstrating the scope and nature of the impairment, Dr. Betz testified that the present impairment was at least fifty percent (50%) due to KLINE's pre-existing impairment. (ROA 15:24-27, 16:1-10). The Appeals Officer concluded that Dr. Betz and Dr. Anderson established the underlying basis for apportionment as required by NAC 616C.490(5)-(7). (ROA 16:10-15). CITY OF RENO argues and the Court finds that KLINE's contention that apportionment is improper due to a lack of prior documentation of the pre-existing, ratable condition is unpersuasive where the Appeals Officer found Dr. Betz has expressly identified the x-rays, historical records, and diagnoses confirming KLINE's prior impairment as required by NAC 616C.490(5).

Following review of the Appeals Officer's Decision, the Court finds the Appeals Officer did not commit any clear error of law nor arbitrary or capricious abuse of discretion. As discussed supra, the Court finds the Appeals Officer correctly applied NRS 616C.490 and NAC 616C.490. In

addition, the Court finds the Decision is supported by substantial evidence and the Appeals Officer's findings of fact and conclusions of law in the Decision complied with the requirements set forth in NRS 233B.125. KLINE was properly awarded 6% PPD award, which apportioned 25% WPI of the cervical spine as 75% non-industrial and 25% industrial. Therefore, the Court finds there is no basis to grant review and the Petition should be denied.

Based on the foregoing and good cause appearing,

IT IS HEREBY ORDERED that KIMBERLY KLINE's Petition for Judicial Review is DENIED and the decision of the Appeals Officer, dated August 20, 2019, is AFFIRMED.

DATED this 10 day of February, 2021.

Connie J. Steinheimer
DISTRICT JUDGE

CERTIFICATE OF SERVICE

CASE NO. CV19-01683

I certify that I am an employee of the SECOND JUDICIAL DISTRICT COURT of the STATE OF NEVADA, COUNTY OF WASHOE; that on the 10 day of February, 2021, I filed the **ORDER DENYING PETITION FOR JUDICIAL REVIEW** with the Clerk of the Court.

I further certify that I transmitted a true and correct copy of the foregoing document by the method(s) noted below:

_____**Personal delivery to the following: [NONE]**

XX **Electronically filed with the Clerk of the Court, using the eFlex system which constitutes effective service for all eFiled documents pursuant to the eFile User Agreement.**

TIMOTHY ROWE, ESQ. for CANNON COCHRAN MANAGEMENT SERVICES, CITY OF RENO

LISA ALSTEAD, ESQ. for CANNON COCHRAN MANAGEMENT SERVICES, CITY OF RENO

HERBERT SANTOS, JR., ESQ. for KIMBERLY M KLINE

_____**Transmitted document to the Second Judicial District Court mailing system in a sealed envelope for postage and mailing by Washoe County using the United States Postal Service in Reno, Nevada: [NONE]**

_____**Placed a true copy in a sealed envelope for service via:**

_____ Reno/Carson Messenger Service – **[NONE]**

_____ Federal Express or other overnight delivery service **[NONE]**

DATED this 10 day of February, 2021.

Senate Bill No. 289–Senator D. Harris

CHAPTER.....

AN ACT relating to workers' compensation; establishing provisions relating to the apportionment of percentages for present and previous disabilities; requiring an insurer to send a written determination regarding an industrial insurance claim by facsimile or other electronic transmission under certain circumstances; making compensation for an industrial injury or occupational disease subject to an attorney's lien; providing for the tolling of certain periods to request a hearing or appeal under certain circumstances; providing for an award of certain costs to a claimant who prevails in a contested claim; providing for the reservation of certain additional rights of a claimant who accepts a lump sum payment for a permanent partial disability; revising provisions governing the appointment of a vocational rehabilitation counselor for an injured employee; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires, in a case where an injured employee is determined to have a permanent partial disability and there is a previous disability, 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. (NRS 616C.490) **Sections 1 and 7** of this bill revise these provisions to prohibit: (1) an apportionment of percentages of disabilities where no rating evaluation was performed for the previous disability unless the insurer proves by a preponderance of the evidence that certain specific medical evidence supports a specific percentage of previous disability; and (2) any reduction of the percentage of present impairment if no medical documentation or health care records of a preexisting impairment exist, unless certain other evidentiary requirements are satisfied. **Section 7** also requires an insurer to commence making installment payments to an injured employee, within a specified period of time and without requiring the employee to elect a method of payment, for that portion of an award of compensation for permanent partial disability which is not in dispute.

Existing law requires an injured employee to submit to an examination and any necessary immediate medical attention by a physician or chiropractor and requires the physician or chiropractor to complete and file a claim for compensation. (NRS 616C.010, 616C.040, 616C.075, 616C.095) **Sections 1.4, 1.6, 2.2 and 2.4** of this bill authorize the examination and treatment to be provided by a physician assistant or advanced practice registered nurse and, if so provided, require the physician assistant or advanced practice registered nurse to file a claim for compensation and provide a copy of the claim form to the injured employee.

Existing law requires an insurer to mail a written determination regarding a claim for compensation under industrial insurance. (NRS 616C.065, 617.356) **Sections 2 and 10** of this bill require the insurer to send its determination by facsimile or other electronic transmission, if so requested, to the claimant or the

person acting on behalf of the claimant and retain proof of successful transmission of the facsimile.

Existing law provides that, except in matters relating to child support, compensation payable or paid for an industrial injury or occupational disease is not assignable and is exempt from attachment, garnishment and execution. (NRS 616C.205) **Section 3** of this bill provides that such compensation may also be subject to an attorney's lien.

Existing law sets forth certain limits on the period of time in which an aggrieved party may request a hearing before a hearing officer or appeal from a decision of a hearing officer. (NRS 616C.315, 616C.345) **Sections 4 and 6** of this bill provide that periods within which a request for a hearing or an appeal may be filed may be tolled if the insurer fails to mail or, if so requested, send by facsimile or other electronic transmission a determination regarding a claim for compensation.

Existing law provides that if a contested claim for compensation is decided in favor of the claimant, he or she is entitled to an award of interest. (NRS 616C.335) **Section 5** of this bill provides that the claimant is also entitled to an award of certain costs and sets forth the procedure for requesting costs and adjudicating disputes for such costs.

Existing law provides that a claimant who elects to receive and accepts payment for a permanent partial disability in a lump sum terminates the claimant's benefits and waives certain rights regarding his or her claim, except the right to reopen his or her claim, have the claim considered by his or her insurer, certain rehabilitative services and the right to receive a benefit penalty. (NRS 616C.495) **Section 8** of this bill provides that the claimant also reserves the right to conclude or resolve any contested matter, with certain exceptions, which is pending at the time of the election of payment for a permanent partial disability in a lump sum.

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) Existing law further provides that where a written assessment is requested or a plan for a program of vocational rehabilitation is required and 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. (NRS 616C.541) **Section 9** of this bill requires the counselors listed to be employed by at least three different organizations or entities.

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 a new section to read as follows:

1. If a rating evaluation was completed for a previous disability involving a condition, occupational disease, organ, anatomical structure or other part of the body that is identical to

the condition, occupational disease, organ, anatomical structure or other part of the body 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.

2. If no rating evaluation performed before the date of injury or onset of the occupational disease exists for apportionment of percentage of present and previous disabilities pursuant to subsection 1, the percentage of the present disability must not be reduced unless:

(a) The insurer proves by a preponderance of the evidence that medical documentation or health care records that existed before the date of the injury or onset of the occupational disease that resulted in the present disability demonstrate evidence that the injured employee had an actual impairment or disability involving the condition, occupational disease, organ, anatomical structure or other part of the body that is the subject of the present disability; and

(b) The rating physician or chiropractor states to a reasonable degree of medical or chiropractic probability that, based upon the specific information in the preexisting medical documentation or health care records, the injured employee would have had a specific percentage of disability immediately before the date of the injury or the onset of the occupational disease if, in the instant before the injury or the onset of the occupational disease, the injured employee had been evaluated under the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment that had been adopted by the Division pursuant to NRS 616C.110.

3. The documentation or records relied upon pursuant to subsection 2 must provide specific references to one or more of the following:

(a) Diagnoses;

(b) Measurements;

(c) Imaging studies;

(d) Laboratory testing; or

(e) Other commonly relied upon medical evidence that supports the finding of a preexisting ratable impairment under the specific provisions of the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment that had been adopted by the Division pursuant to NRS 616C.110 at the time of that rating evaluation.

4. If there is physical evidence of a prior surgery to the same organ, anatomical structure or other part of the body being evaluated for the present disability but no medical documentation or health care records regarding that organ, anatomical structure or other part of the body can be obtained, the rating physician or chiropractor may apportion the rating provided that the applicable requirements of subsection 2, other than any requirement to:

(a) Have medical documentation or health care records; or

(b) Base a rating upon medical documentation or health care records,

➥ are satisfied.

5. If there is no physical evidence of a prior surgery to the same organ, anatomical structure or other part of the body being evaluated for the present disability and no medical documentation or health care records of a preexisting whole person impairment for the identical condition, occupational disease, organ, anatomical structure or other part of the body being evaluated for the present disability exist for the purposes of subsection 1 or 2, the percentage of present impairment must not be reduced by any percentage for the previous impairment.

Sec. 1.2. NRS 616C.005 is hereby amended to read as follows:

616C.005 On or before September 1 of each year:

1. An insurer shall distribute to each employer that it insures any form for reporting injuries that has been revised within the previous 12 months.

2. The Administrator shall make available to physicians ***,*** ~~[and]~~ chiropractors ***, physician assistants and advanced practice registered nurses*** any form for reporting injuries that has been revised within the previous 12 months.

Sec. 1.4. NRS 616C.010 is hereby amended to read as follows:

616C.010 1. Whenever any accident occurs to any employee, the employee shall forthwith report the accident and the injury resulting therefrom to his or her employer.

2. When an employer learns of an accident, whether or not it is reported, the employer may direct the employee to submit to, or the employee may request, an examination by a physician ***,*** ~~[or]~~

chiropractor, ***physician assistant or advanced practice registered nurse,*** in order to ascertain the character and extent of the injury and render medical attention which is required immediately. The employer shall:

(a) If the employer's insurer has entered into a contract with an organization for managed care or with providers of health care pursuant to NRS 616B.527, furnish the names, addresses and telephone numbers of:

(1) Two or more physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** who are qualified to conduct the examination and who are available pursuant to the terms of the contract, if there are two or more such physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** within 30 miles of the employee's place of employment; or

(2) One or more physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** who are qualified to conduct the examination and who are available pursuant to the terms of the contract, if there are not two or more such physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** within 30 miles of the employee's place of employment.

(b) If the employer's insurer has not entered into a contract with an organization for managed care or with providers of health care pursuant to NRS 616B.527, furnish the names, addresses and telephone numbers of:

(1) Two or more physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** who are qualified to conduct the examination, if there are two or more such physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** within 30 miles of the employee's place of employment; or

(2) One or more physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** who are qualified to conduct the examination, if there are not two or more such physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** within 30 miles of the employee's place of employment.

3. From among the names furnished by the employer pursuant to subsection 2, the employee shall select one of those physicians **,** ~~[or]~~ chiropractors **,** ***physician assistants or advanced practice registered nurses*** to conduct the examination, but the employer shall not require the employee to select a particular physician **,** ~~[or]~~ chiropractor **,** ***physician assistant or advanced practice registered***

nurse from among the names furnished by the employer. Thereupon, the examining physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse, as applicable,*** shall report forthwith to the employer and to the insurer the character and extent of the injury. The employer shall not require the employee to disclose or permit the disclosure of any other information concerning the employee's physical condition except as required by NRS 616C.177.

4. Further medical attention, except as otherwise provided in NRS 616C.265, must be authorized by the insurer.

5. This section does not prohibit an employer from requiring the employee to submit to an examination by a physician or chiropractor specified by the employer at any convenient time after medical attention which is required immediately has been completed.

6. An employee leasing company must provide to each employee covered under an employee leasing contract instructions on how to notify the leasing company supervisor and client company of an injury in plain, clear language placed in conspicuous type in a specifically labeled area of instructions given to the employee.

Sec. 1.6. NRS 616C.040 is hereby amended to read as follows:

616C.040 1. Except as otherwise provided in this section, a treating physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** shall, within 3 working days after first providing treatment to an injured employee for a particular injury, complete and file a claim for compensation with the employer of the injured employee and the employer's insurer. If the employer is a self-insured employer, the treating physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** shall file the claim for compensation with the employer's third-party administrator. If the physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** files the claim for compensation by electronic transmission, the physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** shall, upon request, mail to the insurer or third-party administrator the form ***prescribed by the Administrator for a claim for compensation*** that ~~[contains the original signatures of]~~ ***is signed by*** the injured employee and the physician ***,*** ~~[or]~~ chiropractor ***,*** ~~[.]~~ ***physician assistant or advanced practice registered nurse.*** The form must be mailed within 7 days after receiving such a request.

2. A physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** who has a duty to file a claim

for compensation pursuant to subsection 1 may delegate the duty to ***a physician assistant or an advanced practice registered nurse at*** a medical facility. If the physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** delegates the duty to ***a physician assistant or an advanced practice registered nurse at*** a medical facility:

(a) The ***physician assistant or advanced practice registered nurse, as applicable, at the*** medical facility must comply with the filing requirements set forth in this section; and

(b) The delegation must be in writing and signed by:

(1) The ***delegating*** physician ***,*** ~~[or]~~ chiropractor ~~[,]~~ ***, physician assistant or advanced practice registered nurse;*** and

(2) An authorized representative of the medical facility.

3. A claim for compensation required by subsection 1 must ~~[be]~~ ***:***

(a) Be filed on a form prescribed by the Administrator ~~[.]~~ ***; and***

(b) Be signed with the original or electronic signatures of the injured employee and:

(1) The physician, chiropractor, physician assistant or advanced practice registered nurse who treated the injured employee; or

(2) The physician assistant or advanced practice registered nurse to whom the duty to file a claim for compensation is delegated pursuant to subsection 2.

4. If a claim for compensation is accompanied by a certificate of disability, the certificate must include a description of any limitation or restrictions on the injured employee's ability to work.

5. ***A copy of the completed form that is required to be filed pursuant to subsection 3 and which is fully executed with the required original or electronic signatures must be provided to the injured employee at the time of discharge.***

6. Each physician, chiropractor ~~[and]~~ ***, physician assistant, advanced practice registered nurse and*** medical facility that treats injured employees, each insurer, third-party administrator and employer, and the Division shall maintain at their offices a sufficient supply of the forms prescribed by the Administrator for filing a claim for compensation.

~~[6.]~~ ***7.*** The Administrator may impose an administrative fine of not more than $1,000 for each violation of subsection 1 on:

(a) A ***treating*** physician ***,*** ~~[or]~~ chiropractor ~~[,]~~ ***, physician assistant or advanced practice registered nurse;*** or

(b) A ***physician assistant or advanced practice registered nurse at a*** medical facility if the duty to file the claim for compensation

has been delegated to ~~[the medical facility]~~ ***him or her*** pursuant to this section.

Sec. 1.8. NRS 616C.045 is hereby amended to read as follows:

616C.045 1. Except as otherwise provided in NRS 616B.727, within 6 working days after the receipt of a claim for compensation from a physician ***,*** ~~[or]~~ chiropractor, ***physician assistant or advanced practice registered nurse,*** or a medical facility if the duty to file the claim for compensation has been delegated to the medical facility pursuant to NRS 616C.040, an employer shall complete and file with his or her insurer or third-party administrator an employer's report of industrial injury or occupational disease.

2. The report must:

(a) Be filed on a form prescribed by the Administrator;

(b) Be signed by the employer or the employer's designee;

(c) Contain specific answers to all questions required by the regulations of the Administrator; and

(d) Be accompanied by a statement of the wages of the employee if the claim for compensation received from the treating physician ***,*** ~~[or]~~ chiropractor, ***physician assistant or advanced practice registered nurse,*** or a medical facility if the duty to file the claim for compensation has been delegated to the medical facility pursuant to NRS 616C.040, indicates that the injured employee is expected to be off work for 5 days or more.

3. An employer who files the report required by subsection 1 by electronic transmission shall, upon request, mail to the insurer or third-party administrator the form that contains the original signature of the employer or the employer's designee. The form must be mailed within 7 days after receiving such a request.

4. The Administrator shall impose an administrative fine of not more than $1,000 on an employer for each violation of this section.

Sec. 2. NRS 616C.065 is hereby amended to read as follows:

616C.065 1. Except as otherwise provided in NRS 616C.136, within 30 days after the insurer has been notified of an industrial accident, every insurer shall:

(a) Accept a claim for compensation, notify the claimant or the person acting on behalf of the claimant that the claim has been accepted and commence payment of the claim; or

(b) Deny the claim and notify the claimant or the person acting on behalf of the claimant and the Administrator that the claim has been denied.

2. If an insurer is ordered by the Administrator, a hearing officer, an appeals officer, a district court, the Court of Appeals or the Supreme Court of Nevada to make a new determination,

including, without limitation, a new determination regarding the acceptance or denial of a claim for compensation, the insurer shall make the new determination within 30 days after the date on which the insurer has been ordered to do so.

3. Payments made by an insurer pursuant to this section are not an admission of liability for the claim or any portion of the claim.

4. Except as otherwise provided in this subsection, if an insurer unreasonably delays or refuses to pay the claim within 30 days after the insurer has been notified of an industrial accident, the insurer shall pay upon order of the Administrator an additional amount equal to three times the amount specified in the order as refused or unreasonably delayed. This payment is for the benefit of the claimant and must be paid to the claimant with the compensation assessed pursuant to chapters 616A to 617, inclusive, of NRS. The provisions of this section do not apply to the payment of a bill for accident benefits that is governed by the provisions of NRS 616C.136.

5. The insurer shall notify the claimant or the person acting on behalf of the claimant that a claim has been accepted or denied pursuant to subsection 1 or 2 by:

(a) Mailing its written determination to the claimant or the person acting on behalf of the claimant ~~[,]~~ and

~~[(b) If]~~ ***, if*** the claim has been denied, in whole or in part, obtaining a certificate of mailing ~~[.]~~ ***; or***

(b) If and as requested by the claimant or the person acting on behalf of the claimant, sending its written determination to the claimant or the person acting on behalf of the claimant by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable and retaining proof of a successful transmission and receipt of the facsimile or other electronic transmission, as applicable.

6. The failure of the insurer to ~~[obtain]~~ ***, as applicable:***

(a) Obtain a certificate of mailing as required by paragraph ~~[(b)]~~ ***(a)*** of subsection 5 shall be deemed to be a failure of the insurer to mail the written determination of the denial of a claim as required by this section ~~[.]~~ ***; or***

(b) Retain proof of a successful transmission and receipt of the facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable as required by paragraph (b) of subsection 5 shall be deemed to be a failure of the insurer to send by facsimile or other electronic transmission the written determination regarding a claim as required by this section.

7. The failure of the insurer to indicate the acceptance or denial of a claim for a part of the body or condition does not constitute a denial or acceptance thereof.

8. Upon request, the insurer shall provide a copy of the certificate of mailing, if any, ***or proof of a successful transmission and receipt of the facsimile or other electronic transmission, as applicable,*** to the claimant or the person acting on behalf of the claimant.

9. For the purposes of this section, the insurer shall ~~[mail]~~ ***either:***

(a) Mail the written determination to:

~~[(a)]~~ ***(1)*** The mailing address of the claimant or the person acting on behalf of the claimant that is provided on the form prescribed by the Administrator for filing the claim; or

~~[(b)]~~ ***(2)*** Another mailing address if the claimant or the person acting on behalf of the claimant provides to the insurer written notice of another mailing address ~~[.]~~ ***; or***

(b) If and as requested by the claimant or the person acting on behalf of the claimant, send the written determination by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable to the claimant or the person acting on behalf of the claimant.

10. As used in this section, "certificate of mailing" means a receipt that provides evidence of the date on which the insurer presented its written determination to the United States Postal Service for mailing.

Sec. 2.2. NRS 616C.075 is hereby amended to read as follows:

616C.075 ***1.*** If an employee is properly directed to submit to a physical examination and the employee refuses to permit the treating physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** to make an examination and to render medical attention as may be required immediately, no compensation may be paid for the injury claimed to result from the accident.

2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 2.4. NRS 616C.095 is hereby amended to read as follows:

616C.095 ***1.*** The physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** shall inform the

injured employee of the injured employee's rights under chapters 616A to 616D, inclusive, or chapter 617 of NRS and lend all necessary assistance in making application for compensation and such proof of other matters as required by the rules of the Division, without charge to the employee.

2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 2.6. NRS 616C.098 is hereby amended to read as follows:

616C.098 ***1.*** Certain phrases relating to a claim for compensation for an industrial injury or occupational disease and used by a physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** 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.]~~ ***(a)*** "Directly connect this injury or occupational disease as job incurred"; and

~~[2.]~~ ***(b)*** "A degree of reasonable medical probability that the condition in question was caused by the industrial injury."

2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 2.8. NRS 616C.130 is hereby amended to read as follows:

616C.130 ***1.*** The insurer shall not authorize the payment of any money to a physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** for services rendered by the physician ***,*** ~~[or]~~ chiropractor, ***physician assistant or advanced practice registered nurse,*** as applicable, in attending an injured employee until an itemized statement for the services has been received by the insurer accompanied by a certificate of the physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** stating that a duplicate of the itemized statement has been filed with the employer of the injured employee.

2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced

practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 3. NRS 616C.205 is hereby amended to read as follows:

616C.205 Except as otherwise provided in this section and NRS ***18.015,*** 31A.150 and 31A.330, compensation payable or paid under chapters 616A to 616D, inclusive, or chapter 617 of NRS, whether determined or due, or not:

1. Is not assignable before the issuance and delivery of the check or the deposit of any payment for compensation pursuant to NRS 616C.409;
2. Is exempt from attachment, garnishment and execution; and
3. Does not pass to any other person by operation of law.

➥ In the case of the death of an injured employee covered by chapters 616A to 616D, inclusive, or chapter 617 of NRS from causes independent from the injury for which compensation is payable, any compensation due the employee which was awarded or accrued but for which a check was not issued or delivered or for which payment was not made pursuant to NRS 616C.409 at the date of death of the employee is payable to the dependents of the employee as defined in NRS 616C.505.

Sec. 3.3. NRS 616C.265 is hereby amended to read as follows:

616C.265 1. Except as otherwise provided in NRS 616C.280, every employer operating under chapters 616A to 616D, inclusive, of NRS, alone or together with other employers, may make arrangements to provide accident benefits as defined in those chapters for injured employees.

2. Employers electing to make such arrangements shall notify the Administrator of the election and render a detailed statement of the arrangements made, which arrangements do not become effective until approved by the Administrator.

3. Every employer who maintains a hospital of any kind for his or her employees, or who contracts for the hospital care of injured employees, shall, on or before January 30 of each year, make a written report to the Administrator for the preceding year, which must contain a statement showing:

(a) The total amount of hospital fees collected, showing separately the amount contributed by the employees and the amount contributed by the employers;

(b) An itemized account of the expenditures, investments or other disposition of such fees; and

(c) What balance, if any, remains.

4. Every employer who provides accident benefits pursuant to this section:

(a) Shall, in accordance with regulations adopted by the Administrator, make a written report to the Division of that employer's actual and expected annual expenditures for claims and such other information as the Division deems necessary to calculate an estimated or final annual assessment and shall, to the extent that the regulations refer to the responsibility of insurers to make such reports, be deemed to be an insurer.

(b) Shall pay the assessments collected pursuant to NRS 232.680 and 616A.430.

5. The reports required by the provisions of subsections 3 and 4 must be verified:

(a) If the employer is a natural person, by the employer;

(b) If the employer is a partnership, by one of the partners;

(c) If the employer is a corporation, by the secretary, president, general manager or other executive officer of the corporation; or

(d) If the employer has contracted with a physician or chiropractor for the hospital care of injured employees, by the physician or chiropractor.

6. No employee is required to accept the services of a physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** provided by his or her employer, but may seek professional medical services of the employee's choice as provided in NRS 616C.090. Expenses arising from such medical services must be paid by the employer who has elected to provide benefits, pursuant to the provisions of this section, for the employer's injured employees.

7. Every employer who fails to notify the Administrator of such election and arrangements, or who fails to render the financial reports required, is liable for accident benefits as provided by NRS 616C.255.

8. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 3.7. NRS 616C.270 is hereby amended to read as follows:

616C.270 1. Every employer who has elected to provide accident benefits for his or her injured employees shall prepare and submit a written report to the Administrator:

(a) Within 6 days after any accident if an injured employee is examined or treated by a physician ***,*** ~~[or]~~ chiropractor ~~[;]~~ ***, physician assistant or advanced practice registered nurse;*** and

(b) If the injured employee receives additional medical services.

2. The Administrator shall review each report to determine whether the employer is furnishing the accident benefits required by chapters 616A to 616D, inclusive, of NRS.

3. The content and form of the written reports must be prescribed by the Administrator.

4. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 4. NRS 616C.315 is hereby amended to read as follows:

616C.315 1. Any person who is subject to the jurisdiction of the hearing officers pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS may request a hearing before a hearing officer of any matter within the hearing officer's authority. The insurer shall provide, without cost, the forms necessary to request a hearing to any person who requests them.

2. A hearing must not be scheduled until the following information is provided to the hearing officer:

(a) The name of:

(1) The claimant;

(2) The employer; and

(3) The insurer or third-party administrator;

(b) The number of the claim; and

(c) If applicable, a copy of the letter of determination being appealed or, if such a copy is unavailable, the date of the determination and the issues stated in the determination.

3. Except as otherwise provided in NRS 616B.772, 616B.775, 616B.787, 616C.305 and 616C.427, a person who is aggrieved by:

(a) A written determination of an insurer; or

(b) The failure of an insurer to respond within 30 days to a written request mailed to the insurer by the person who is aggrieved,

➥ may appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer. Such a request must include the information required pursuant to subsection 2 and, except as otherwise provided in subsections 4 and 5, must be filed within 70 days after the date on which the notice of the insurer's determination was mailed ***or, if requested by the claimant or the person acting on behalf of the claimant, sent by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable*** by the insurer or the unanswered written request

was mailed to the insurer, as applicable. The failure of an insurer to respond to a written request for a determination within 30 days after receipt of such a request shall be deemed by the hearing officer to be a denial of the request.

4. The period specified in subsection 3 within which a request for a hearing must be filed may be ~~[extended]~~ ***:***

(a) Extended for an additional 90 days if the person aggrieved shows by a preponderance of the evidence that the person was diagnosed with a terminal illness or was informed of the death or diagnosis of a terminal illness of his or her spouse, parent or child.

(b) Tolled if the insurer fails to mail or, if requested by the claimant or the person acting on behalf of the claimant, send by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable a determination.

5. Failure to file a request for a hearing within the period specified in subsection 3 may be excused if the person aggrieved shows by a preponderance of the evidence that the person did not receive the notice of the determination and the forms necessary to request a hearing. The claimant or employer shall notify the insurer of a change of address.

6. The hearing before the hearing officer must be conducted as expeditiously and informally as is practicable.

7. The parties to a contested claim may, if the claimant is represented by legal counsel, agree to forego a hearing before a hearing officer and submit the contested claim directly to an appeals officer.

8. A claimant may, with regard to a contested claim arising from the provisions of NRS 617.453, 617.455, 617.457, 617.485 or 617.487 as described in subsection 2 of NRS 616C.345, submit the contested claim directly to an appeals officer pursuant to subsection 2 of NRS 616C.345 without the agreement of any other party.

Sec. 4.5. NRS 616C.330 is hereby amended to read as follows:

616C.330 1. The hearing officer shall:

(a) Except as otherwise provided in subsection 2 of NRS 616C.315, within 5 days after receiving a request for a hearing, set the hearing for a date and time within 30 days after his or her receipt of the request at a place in Carson City, Nevada, or Las Vegas, Nevada, or upon agreement of one or more of the parties to pay all additional costs directly related to an alternative location, at any other place of convenience to the parties, at the discretion of the hearing officer;

(b) Give notice by mail or by personal service to all interested parties to the hearing at least 15 days before the date and time scheduled; and

(c) Conduct hearings expeditiously and informally.

2. The notice must include a statement that the injured employee may be represented by a private attorney or seek assistance and advice from the Nevada Attorney for Injured Workers.

3. If 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, the hearing officer may order an independent medical examination, which must not involve treatment, and refer the employee to a physician or chiropractor of his or her choice who has demonstrated special competence to treat the particular medical condition of the employee, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. If the medical question concerns the rating of a permanent disability, the hearing officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected 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 injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any medical examination requested by the hearing officer.

4. The hearing officer may consider the opinion of an examining physician ***,*** ~~[or]~~ chiropractor, ***physician assistant or advanced practice registered nurse,*** in addition to the opinion of an authorized treating physician ***,*** ~~[or]~~ chiropractor, ***physician assistant or advanced practice registered nurse,*** in determining the compensation payable to the injured employee.

5. If an injured employee has requested payment for the cost of obtaining a second determination of his or her percentage of disability pursuant to NRS 616C.100, the hearing officer shall decide whether the determination of the higher percentage of disability made pursuant to NRS 616C.100 is appropriate and, if so, may order the insurer to pay to the employee an amount equal to the maximum allowable fee established by the Administrator pursuant to NRS 616C.260 for the type of service performed, or the usual fee of that physician or chiropractor for such service, whichever is less.

6. The hearing officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay to the

appropriate person the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

7. The hearing officer may allow or forbid the presence of a court reporter and the use of a tape recorder in a hearing.

8. The hearing officer shall render his or her decision within 15 days after:

(a) The hearing; or

(b) The hearing officer receives a copy of the report from the medical examination the hearing officer requested.

9. The hearing officer shall render a decision in the most efficient format developed by the Chief of the Hearings Division of the Department of Administration.

10. The hearing officer shall give notice of the decision to each party by mail. The hearing officer shall include with the notice of the decision the necessary forms for appealing from the decision.

11. Except as otherwise provided in NRS 616C.380, the decision of the hearing officer is not stayed if an appeal from that decision is taken unless an application for a stay is submitted by a party. If such an application is submitted, the decision is automatically stayed until a determination is made on the application. A determination on the application must be made within 30 days after the filing of the application. If, after reviewing the application, a stay is not granted by the hearing officer or an appeals officer, the decision must be complied with within 10 days after the refusal to grant a stay.

12. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 5. NRS 616C.335 is hereby amended to read as follows:

616C.335 ***1.*** If a contested claim for compensation is decided in favor of the claimant, he or she is entitled to ~~[an]~~ ***:***

(a) An award of interest at the rate of 9 percent on the amount of compensation due the claimant from the date the payment on the claim would be due until the date that payment is made.

(b) As limited by subsection 2, an award of costs against the opposing party as follows:

(1) Clerks' fees.

(2) Reporters' fees for depositions, including a reporter's fee for one copy of each deposition.

(3) Fees for witnesses at an appeals hearing and deposing witnesses, unless the appeals officer finds that the witness was called at the instance of the prevailing party without reason or necessity.

(4) Reasonable fees of not more than five expert witnesses in an amount of not more than the fee allowable for an independent medical examination as set forth in the schedule of fees established by the Administrator pursuant to NRS 616C.260 for each witness, unless the appeals officer allows a fee in a greater amount after determining that the circumstances surrounding the expert's testimony were of such necessity as to require the greater amount of the fee.

(5) The fee of any sheriff or licensed process server for the delivery or service of any summons or subpoena used in the action, unless the appeals officer determines that the service was not necessary.

(6) Compensation for the official reporter or reporter pro tempore.

(7) Reasonable costs for photocopies.

(8) Reasonable costs for postage.

(9) Reasonable costs for travel and lodging incurred taking depositions and conducting discovery.

(10) Any other reasonable and necessary expense incurred in connection with the action, including reasonable and necessary expenses for computerized services for legal research.

2. Costs awarded pursuant to subsection 1 must be limited to the costs incurred as a result of the litigation of those issues which were decided in favor of the claimant.

3. If a claimant is awarded costs pursuant to subsection 1, the claimant shall serve on the insurer and the claimant's employer, not later than 15 calendar days after the decision of an appeals officer, district court, the Court of Appeals or the Supreme Court, a memorandum of the costs in the action or proceeding, which memorandum must be verified by the oath of the claimant, or the claimant's attorney or agent, or by the clerk of the claimant's attorney, stating that to the best of his or her knowledge and belief the costs are correct, and that the costs have been necessarily incurred in the action or proceeding.

4. Not later than 15 calendar days after receipt of service of a copy of a memorandum pursuant to subsection 3, the insurer shall issue to the claimant a determination letter regarding the requested costs, specifically stating in detail:

(a) The costs which are allowed pursuant to paragraph (b) of subsection 1 and subsection 2; and

(b) The costs which are disallowed pursuant to paragraph (b) of subsection 1 and subsection 2, along with specific reasons for the disallowance of those costs.

5. Costs which are allowed by the insurer pursuant to subsection 4, must be paid along with the determination letter to the claimant or, if the claimant is represented, to the claimant's counsel.

6. Any party aggrieved by the determination may file a request for appeal directly to an appeals officer not later than 30 days after receipt of the determination letter.

Sec. 6. NRS 616C.345 is hereby amended to read as follows:

616C.345 1. Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by, except as otherwise provided in subsections 9 ***,*** ~~[and]~~ 10 ~~[,]~~ ***and 11,*** filing a notice of appeal with an appeals officer within 30 days after the date of the decision.

2. A claimant aggrieved by a written determination of the denial of a claim, in whole or in part, by an insurer, or the failure of an insurer to respond in writing within 30 days to a written request of the claimant mailed to the insurer, concerning a claim arising from the provisions of NRS 617.453, 617.455, 617.457, 617.485 or 617.487 may file a notice of a contested claim with an appeals officer. The notice must include the information required pursuant to subsection 3 and, except as otherwise provided in subsections 9 ~~[and 11,]~~ ***to 12, inclusive,*** must be filed within 70 days after the date on which the notice of the insurer's determination was mailed ***or, if requested by the claimant or the person acting on behalf of the claimant, sent by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable*** by the insurer or the unanswered written request was mailed to the insurer, as applicable. The failure of an insurer to respond in writing to a written request for a determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request. The insurer shall provide, without cost, the forms necessary to file a notice of a contested claim to any person who requests them.

3. A hearing must not be scheduled until the following information is provided to the appeals officer:

(a) The name of:

(1) The claimant;

(2) The employer; and

(3) The insurer or third-party administrator;

(b) The number of the claim; and

(c) If applicable, a copy of the letter of determination being appealed or, if such a copy is unavailable, the date of the determination and the issues stated in the determination.

4. If a dispute is required to be submitted to a procedure for resolving complaints pursuant to NRS 616C.305 and:

(a) A final determination was rendered pursuant to that procedure; or

(b) The dispute was not resolved pursuant to that procedure within 14 days after it was submitted,

➥ any party to the dispute may, except as otherwise provided in subsections 9 ~~[and 10,]~~ ***to 12, inclusive,*** file a notice of appeal within 70 days after the date on which the final determination was mailed to the employee, or the dependent of the employee, or the unanswered request for resolution was submitted. Failure to render a written determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request.

5. Except as otherwise provided in NRS 616C.380, the filing of a notice of appeal does not automatically stay the enforcement of the decision of a hearing officer or a determination rendered pursuant to NRS 616C.305. The appeals officer may order a stay, when appropriate, upon the application of a party. If such an application is submitted, the decision is automatically stayed until a determination is made concerning the application. A determination on the application must be made within 30 days after the filing of the application. If a stay is not granted by the officer after reviewing the application, the decision must be complied with within 10 days after the date of the refusal to grant a stay.

6. Except as otherwise provided in subsections 3 and 7, within 10 days after receiving a notice of appeal pursuant to this section or NRS 616C.220, 616D.140 or 617.401, or within 10 days after receiving a notice of a contested claim pursuant to subsection 7 of NRS 616C.315, the appeals officer shall:

(a) Schedule a hearing on the merits of the appeal or contested claim for a date and time within 90 days after receipt of the notice at a place in Carson City, Nevada, or Las Vegas, Nevada, or upon agreement of one or more of the parties to pay all additional costs directly related to an alternative location, at any other place of convenience to the parties, at the discretion of the appeals officer; and

(b) Give notice by mail or by personal service to all parties to the matter and their attorneys or agents at least 30 days before the date and time scheduled.

7. Except as otherwise provided in subsection ~~[12.]~~ ***13,*** a request to schedule the hearing for a date and time which is:

(a) Within 60 days after the receipt of the notice of appeal or contested claim; or

(b) More than 90 days after the receipt of the notice or claim,

➥ may be submitted to the appeals officer only if all parties to the appeal or contested claim agree to the request.

8. An appeal or contested claim may be continued upon written stipulation of all parties, or upon good cause shown.

9. The period specified in subsection 1, 2 or 4 within which a notice of appeal or a notice of a contested claim must be filed may be extended for an additional 90 days if the person aggrieved shows by a preponderance of the evidence that the person was diagnosed with a terminal illness or was informed of the death or diagnosis of a terminal illness of the person's spouse, parent or child.

10. ***The period specified in subsection 2 within which a notice of appeal or a notice of a contested claim must be filed may be tolled if the insurer fails to mail or, if requested by the claimant or the person acting on behalf of the claimant, send a determination by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable.***

11. Failure to file a notice of appeal within the period specified in subsection 1 or 4 may be excused if the party aggrieved shows by a preponderance of the evidence that he or she did not receive the notice of the determination and the forms necessary to appeal the determination. The claimant, employer or insurer shall notify the hearing officer of a change of address.

~~[11.]~~ ***12.*** Failure to file a notice of a contested claim within the period specified in subsection 2 may be excused if the claimant shows by a preponderance of the evidence that he or she did not receive the notice of the determination and the forms necessary to file the notice. The claimant or employer shall notify the insurer of a change of address.

~~[12.]~~ ***13.*** Within 10 days after receiving a notice of a contested claim pursuant to subsection 2, the appeals officer shall:

(a) Schedule a hearing on the merits of the contested claim for a date and time within 60 days after his or her receipt of the notice at a place in Carson City, Nevada, or Las Vegas, Nevada, or upon agreement of one or more of the parties to pay all additional costs directly related to an alternative location, at any other place of

convenience to the parties, at the discretion of the appeals officer; and

(b) Give notice by mail or by personal service to all parties to the matter and their attorneys or agents within 10 days after scheduling the hearing.

➥ The scheduled date must allow sufficient time for full disclosure, exchange and examination of medical and other relevant information. A party may not introduce information at the hearing which was not previously disclosed to the other parties unless all parties agree to the introduction.

Sec. 6.3. NRS 616C.350 is hereby amended to read as follows:

616C.350 1. Any physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** who attends an employee within the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS in a professional capacity, may be required to testify before an appeals officer. A physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** who testifies is entitled to receive the same fees as witnesses in civil cases and, if the appeals officer so orders at his or her own discretion, a fee equal to that authorized for a consultation by the appropriate schedule of fees for physicians ***,*** ~~[or]~~ chiropractors ~~[.]~~ ***, physician assistants or advanced practice registered nurses, if any.*** These fees must be paid by the insurer.

2. Information gained by the attending physician ***,*** ~~[or]~~ chiropractor ***, physician assistant or advanced practice registered nurse*** while in attendance on the injured employee is not a privileged communication if:

(a) Required by an appeals officer for a proper understanding of the case and a determination of the rights involved; or

(b) The information is related to any fraud that has been or is alleged to have been committed in violation of the provisions of this chapter or chapter 616A, 616B, 616D or 617 of NRS.

3. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 6.7. NRS 616C.360 is hereby amended to read as follows:

616C.360 1. A stenographic or electronic record must be kept of the hearing before the appeals officer and the rules of evidence applicable to contested cases under chapter 233B of NRS apply to the hearing.

2. The appeals officer must hear any matter raised before him or her on its merits, including new evidence bearing on the matter.

3. If there is a medical question or dispute concerning an injured employee's condition or concerning the necessity of treatment for which authorization for payment has been denied, the appeals officer may:

(a) Order an independent medical examination and refer the employee to a physician or chiropractor of his or her choice who has demonstrated special competence to treat the particular medical condition of the employee, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. If the medical question concerns the rating of a permanent disability, the appeals officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians or 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. The insurer shall pay the costs of any examination requested by the appeals officer.

(b) If the medical question or dispute is relevant to an issue involved in the matter before the appeals officer and all parties agree to the submission of the matter to an independent review organization, submit the matter to an independent review organization in accordance with NRS 616C.363 and any regulations adopted by the Commissioner.

4. The appeals officer may consider the opinion of an examining physician ***,*** ~~[or]~~ chiropractor, ***physician assistant or advanced practice registered nurse,*** in addition to the opinion of an authorized treating physician ***,*** ~~[or]~~ chiropractor, ***physician assistant or advanced practice registered nurse,*** in determining the compensation payable to the injured employee.

5. If an injured employee has requested payment for the cost of obtaining a second determination of his or her percentage of disability pursuant to NRS 616C.100, the appeals officer shall decide whether the determination of the higher percentage of disability made pursuant to NRS 616C.100 is appropriate and, if so, may order the insurer to pay to the employee an amount equal to the maximum allowable fee established by the Administrator pursuant to NRS 616C.260 for the type of service performed, or the usual fee of that physician or chiropractor for such service, whichever is less.

6. The appeals officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay to the

appropriate person the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

7. Any party to the appeal or contested case or the appeals officer may order a transcript of the record of the hearing at any time before the seventh day after the hearing. The transcript must be filed within 30 days after the date of the order unless the appeals officer otherwise orders.

8. Except as otherwise provided in subsection 9, the appeals officer shall render a decision:

(a) If a transcript is ordered within 7 days after the hearing, within 30 days after the transcript is filed; or

(b) If a transcript has not been ordered, within 30 days after the date of the hearing.

9. The appeals officer shall render a decision on a contested claim submitted pursuant to subsection 2 of NRS 616C.345 within 15 days after:

(a) The date of the hearing; or

(b) If the appeals officer orders an independent medical examination, the date the appeals officer receives the report of the examination,

➥ unless both parties to the contested claim agree to a later date.

10. The appeals officer may affirm, modify or reverse any decision made by a hearing officer and issue any necessary and proper order to give effect to his or her decision.

11. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 7. 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. Except as otherwise provided in subsection 3:

(a) 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.

(b) Unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor:

(1) 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.

(2) 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. Notwithstanding any other provision of law, an injured employee or the legal representative of an injured employee may, at any time, without limitation, request that the Administrator select a rating physician or chiropractor from the list of qualified physicians and chiropractors designated by the Administrator. The Administrator, upon receipt of the request, shall immediately select for the injured employee the rating physician or chiropractor who is next in rotation on the list, according to the area of specialization.

4. If an insurer contacts a 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.

5. 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.

6. 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.

7. 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.

8. 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.

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

10. ~~[Except as otherwise provided in subsection 11, if]~~ ***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.]~~ ***pursuant to section 1 of this act.***

11. ~~[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.]~~ ***In the event of a dispute over an award of compensation for permanent partial disability, the insurer shall commence making installment payments to the injured employee for that portion of the award that is not in dispute:***

(a) Not later than the date by which such payment is required pursuant to subsection 8 or 9, as applicable; and

(b) Without requiring the injured employee to make an election whether to receive his or her compensation in installment payments or in a lump sum.

12. 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.

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

14. 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. 8. 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 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]~~ ***Except as otherwise provided in paragraph (d), 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 ~~[.~~ ~~"~~~~]~~ ***; and***

(d) The right of the claimant to conclude or resolve any contested matter which is pending at the time that the claimant executes his or her election to receive his or her payment for a permanent partial disability in a lump sum. The provisions of this paragraph do not apply to:

(1) The scope of the claim;

(2) The claimant's stable and ratable status; and

(3) The claimant's average monthly wage.

3. The claimant, when he or she demands payment in a lump sum ~~[,]~~ ***pursuant to subsection 2,*** 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.]~~ ***4.*** 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.]~~ ***5.*** 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.]~~ ***6.*** 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 8 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.]~~ ***7.*** 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. 9. NRS 616C.541 is hereby amended to read as follows:

616C.541 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 ***who are employed by at least three different organizations or entities*** 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.

Sec. 9.5. NRS 616C.545 is hereby amended to read as follows:

616C.545 ***1.*** If an employee does not return to work for 28 consecutive calendar days as a result of an injury arising out of and in the course of his or her employment or an occupational disease, the insurer shall contact the treating physician **,** ~~[or]~~ chiropractor **,** ***physician assistant or advanced practice registered nurse*** to determine whether:

~~[1.]~~ ***(a)*** There are physical limitations on the injured employee's ability to work; and

~~[2.]~~ ***(b)*** The limitations, if any, are permanent or temporary.

2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.

Sec. 10. NRS 617.356 is hereby amended to read as follows:

617.356 1. An insurer shall accept or deny a claim for compensation under this chapter and notify the claimant or the person acting on behalf of the claimant pursuant to NRS 617.344 that the claim has been accepted or denied within 30 working days

after the forms for filing the claim for compensation are received pursuant to both NRS 617.344 and 617.352.

2. The insurer shall notify the claimant or the person acting on behalf of the claimant that a claim has been accepted or denied pursuant to subsection 1 by:

(a) Mailing its written determination to the claimant or the person acting on behalf of the claimant ~~[,]~~ and

~~[(b) If]~~ ***, if*** the claim has been denied, in whole or in part, obtaining a certificate of mailing ~~[.]~~ ***; or***

(b) If and as requested by the claimant or the person acting on behalf of the claimant, sending its written determination to the claimant or the person acting on behalf of the claimant by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable and retaining proof of a successful transmission and receipt of the facsimile or other electronic transmission, as applicable.

3. The failure of the insurer to ~~[obtain]~~ ***, as applicable:***

(a) Obtain a certificate of mailing as required by paragraph ~~[(b)]~~ ***(a)*** of subsection 2 shall be deemed to be a failure of the insurer to mail the written determination of the denial of a claim as required by this section ~~[.]~~ ***; or***

(b) Retain proof of a successful transmission and receipt of the facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable, as applicable, as required by paragraph (b) of subsection 2 shall be deemed to be a failure of the insurer to send by facsimile or other electronic transmission the written determination regarding a claim as required by this section.

4. Upon request, the insurer shall provide a copy of the certificate of mailing, if any, ***or proof of a successful transmission and receipt of the facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable, as applicable,*** to the claimant or the person acting on behalf of the claimant.

5. For the purposes of this section, the insurer shall ~~[mail]~~ ***either:***

(a) Mail the written determination to:

~~[(a)]~~ ***(1)*** The mailing address of the claimant or the person acting on behalf of the claimant that is provided on the form prescribed by the Administrator for filing the claim; or

~~[(b)]~~ ***(2)*** Another mailing address if the claimant or the person acting on behalf of the claimant provides to the insurer written notice of another mailing address ~~[.]~~ ***; or***

(b) If and as requested by the claimant or the person acting on behalf of the claimant, send the written determination by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable to the claimant or person acting on behalf of the claimant.

6. As used in this section, "certificate of mailing" means a receipt that provides evidence of the date on which the insurer presented its written determination to the United States Postal Service for mailing.

Sec. 11. The amendatory provisions of this act apply prospectively with regard to any claim pursuant to chapters 616A to 616D, inclusive, or 617 of NRS which is open on the effective date of this act.

Sec. 12. This act becomes effective upon passage and approval.

20 ~~~~~ **21**

2540
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Attorneys for Respondents
CITY OF RENO AND CANNON
COCHRAN MANAGEMENT SERVICES, INC.

IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

* * * * *

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO, ESQ., Sr. Appeals Officer; RAJINDER NIELSEN, ESQ., Appeals Officer, ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

Case No.: CV19-01683

Dept. No.: 4

NOTICE OF ENTRY OF ORDER

PLEASE TAKE NOTICE that on February 10, 2021, the above-entitled Court entered its Order Denying Petition for Judicial Review. A true and correct copy of the Order is attached hereto as **Exhibit 1**.

///

///

AFFIRMATION

The undersigned does hereby affirm that the preceding does not contain the social security number of any person.

DATED this 11th day of February, 2021.

McDONALD CARANO, LLP

By: */s/ Lisa Wiltshire Alstead*
Lisa Wiltshire Alstead, Esq. (NSBN 10470)
100 W. Liberty Street, Tenth Floor
Reno, NV 89501
Attorneys for Respondents

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 11th day of February, 2021, I served the within **NOTICE OF ENTRY OF ORDER DENYING PETITION FOR JUDICIAL REVIEW** upon all parties registered for electronic service through filing with the Clerk of the Court by using the Court's CM/ECF system.

/s/ Angela Shoults
An Employee of McDonald Carano LLP

INDEX OF EXHIBITS

EXHIBIT	DESCRIPTION	NO. OF PAGES
1.	Order Denying Petition for Judicial Review	17

4840-5854-3836, v. 1

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CV19-01683
2021-03-08 02:27:28 PM
Jacqueline Bryant
Clerk of the Court
Transaction # 8330671 : yvloria

1 **$2515**
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5 Attorney for Appellant

6

7 **IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA**

8 **IN AND FOR THE COUNTY OF WASHOE**

9 KIMBERLY KLINE,

10 Appellant,

11 vs.

12 CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO,, ESQ., Sr. Appeals Officer; RAJINDER NIELSEN, ESQ., Appeals Officer; ATTORNEY GENERAL AARON FORD, ESQ.,

18 Respondents.

19

Case No.: CV19-01683

Dept. No.: 4

20 **NOTICE OF APPEAL**

21 NOTICE IS HEREBY GIVEN that Appellant, KIMBERLY KLINE, in the above-entitled
22 action, hereby appeals to the Supreme Court of the State of Nevada, the attached "Order" entered
23 in this action on or about February 10, 2021 which affirmed the Appeals Officer's Decision and
24 Order. The "Notice of Entry of Order" was filed on February 11, 2021.

25 **AFFIRMATION: Pursuant to NRS 239B.030**

26 The undersigned does hereby affirm that this document does not contain the social security

27 ///

28 ///

number of any person.

Respectfully submitted this 8 day of March, 2021.

THE LAW FIRM OF HERB SANTOS, JR.
225 South Arlington Avenue, Suite C
Reno, Nevada 89501

By _____
HERB SANTOS, JR., Esq.
Attorney for Appellant

CERTIFICATE OF SERVICE

Pursuant to N.R.C.P. 5(b), I hereby certify that I am an employee of THE LAW FIRM OF HERB SANTOS, JR. and that on this date, I electronically filed the foregoing document using the ECF system and that on this date I served a true and correct copy of the foregoing document via U.S. Mail to the following:

KIMBERLY KLINE
2835 BONFIRE LANE
RENO, NV 89521

CITY OF RENO
PO BOX 1900
RENO, NV 89505

CCMSI
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AARON FORD, ESQ.
OFFICE OF THE ATTORNEY GENERAL
100 N. CARSON STREET
CARSON CITY, NV 89701

DATED this 8 day of March, 2021.

Jimayne Lee

INDEX OF EXHIBITS

EXHIBIT 1

EXHIBIT 1

FILED
Electronically
CV19-01683
2021-02-10 09:24:22 AM
Jacqueline Bryant
Clerk of the Court
Transaction # 8288432

IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERBVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO, ESQ., Sr. Appeals Officer; RAJINDER NIELSEN, ESQ., Appeals Officer, ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

CASE NO.: CV19-01683

DEPT. NO.: 4

ORDER DENYING PETITION FOR JUDICIAL REVIEW

On August 28, 2019, Petitioner KIMBERLY KLINE, by and through her attorney, Herb Santos, Jr., Esq. of the Law Firm of Herb Santos, Jr., filed a *Petition for Judicial Review*. On September 9, 2019, Respondent the CITY OF RENO and CANNON COCHRAN MANAGEMENT SERVICES, INC. (hereinafter "CCMSI"), by and through their attorney, Timothy E. Rowe, Esq. and Lisa Wiltshire Alstead, Esq. of McDonald Carano LLP, filed a *Statement of Intent to Participate.*

On September 18, 2019, Rajinder K. Rai-Nielsen, Esq., Appeals Officer, filed a *Certification of Transmittal.* Also, on September 18, 2019, the *Record on Appeal in Accordance with the Nevada Administrative Procedure Act (Chapter 233B of NRS)* and a *Transmittal of Record on Appeal* ("ROA") were filed.

On October 16, 2019, an *Order for Briefing Schedule* was entered setting forth the briefing deadlines pursuant to NRS 233B.130.

On October 28, 2019, Petitioner KIMBERLY KLINE and Respondent CITY OF RENO and CCMSI filed a *Stipulation to Extend Time to File Briefs* wherein the parties stipulated and agreed to extend the deadline to file Petitioner's opening brief to December 15, 2019, and Respondent's answering brief to January 20, 2020.

On November 4, 2019, an *Amended Briefing Schedule Order* was entered extending the briefing deadlines in accordance with the October 28, 2019 stipulation. On November 7, 2019, Petitioner KIMBERLY KLINE filed a *Notice of Entry of Order*.

On December 12, 2019, Petitioner KIMBERLY KLINE and Respondent CITY OF RENO and CCMSI filed a second *Stipulation to Extend Time to File Briefs* wherein the parties stipulated and agreed to extend the deadline to file Petitioner's opening brief to January 14, 2020, and Respondent's answering brief to February 14, 2020.

On December 20, 2019, an *Order* granting stipulation to extend time periods set forth in NRS 233B.133 was entered extending the briefing deadlines in accordance with the December 12, 2019 second stipulation. On January 9, 2020, KIMBERLY KLINE filed *Notice of Entry of Order*.

On January 13, 2020, Petitioner KIMBERLY KLINE and Respondent CITY OF RENO and CCMSI filed a third *Stipulation to Extend Time to File Briefs* wherein the parties stipulated and agreed to extend the deadline to file Petitioner's opening brief to February 24, 2020 and Respondent's answering brief to March 24, 2020.

On January 16, 2020, an *Order Granting Stipulation to Extend Deadlines* was entered extending the briefing deadlines in accordance with the January 13, 2020 third stipulation. On January 21, 2020, Petitioner KIMBERLY KLINE filed a *Notice of Entry of Order.*

On February 24, 2020, KIMBERLY KLINE filed *Petitioner's Opening Brief.*

On March 20, 2020, Petitioner KIMBERLY KLINE and Respondent CITY OF RENO and CCMSI filed a fourth *Stipulation to Extend Briefing Deadlines* wherein the parties stipulated and agreed to extend the deadline for Respondent's answering brief to April 23, 2020 and Petitioner's reply brief to May 23, 2020.

On March 23, 2020, a *Second Amended Briefing Schedule Order* was entered extending the deadline for Respondent's answering brief to April 23, 2020 and Petitioner's reply brief to May 23, 2020 pursuant to the parties' stipulation.

On April 23, 2020, the CITY OF RENO filed *Respondent's Answering Brief.* On May 22, 2020, KIMBERLY KLINE filed *Petitioner's Reply Brief.* Thereafter, the parties' briefs were submitted to the Court for consideration.

Also, on May 22, 2020, Petitioner KIMBERLY KLINE filed a *Request for Oral Argument* on the Petition for Judicial Review. On May 27, 2020, CITY OF RENO also filed *Request for Oral Argument* on KIMBERLY KLINE's Petition for Judicial Review. Therefore, on June 17, 2020, the Court found that it would be an appropriate exercise of discretion by the Court to allow for oral arguments on the Petition for Judicial Review and entered *Order to Set.*

On June 26, 2020, the parties filed *Application for Setting*, wherein the parties agreed to a telephonic hearing to be conducted on September 2, 2020. On September 2, 2020, the parties filed a second *Application for Setting*, wherein the parties agree to vacate the September 2, 2020 hearing and reset the hearing for September 30, 2020. On October 5, 2020, the parties filed a third *Application for Setting*, wherein the parties agreed to reset the oral arguments on the Petition for Judicial review to November 2, 2020. On November 2, 2020, the parties filed a fourth *Application for Setting*, wherein the parties vacated the November 2, 2020 hearing, and reset it for November 19, 2020.

On November 19, 2020, the Court heard oral argument on KIMBERLY KLINE'S Petition for Judicial Review via simultaneous audio-visual transmission pursuant to Supreme Court Rules Part IX due to the courthouse's closure in light of the COVID-19 pandemic. At the hearing, Herb Santos, Jr., Esq. argued on behalf of Petitioner KIMBERLY KLINE, who was present for the hearing via simultaneous audio-visual transmission from Washoe County, Nevada. The opposition was argued by Lisa Alstead, Esq., on behalf of the CITY OF RENO. After the hearing, the transcript of the proceeding was submitted to the Court on December 1, 2020. Thereafter, the matter was taken under advisement by the Court.

KIMBERLY KLINE's Petition for Judicial Review arises from a June 25, 2015 industrial injury KLINE suffered when her work vehicle was rear-ended by another vehicle. (ROA 177-182,

395). The June 25, 2015 accident (subject incident) was her second motor vehicle accident within a month. (ROA 409). The first occurred on June 3, 2015 and KLINE's injuries sustained therein were nearly resolved at the time of the second incident. (Id.). On June 25, 2015, following the subject incident, KLINE went to St. Mary's and received medical treatment for back and neck pain. (ROA 182-185, 409-411). KLINE was diagnosed by Dr. Richard Law with an acute lumbar radiculopathy, sprain of the lumbar spine, and acute pain in the lower back. (ROA 410).

On July 23, 2015, the claim was accepted for cervical strain. (ROA 453). KLINE received medical treatment from Dr. Scott Hall, M.D., in addition to chiropractic care and physical therapy. (See generally ROA 296-341). On October 28, 2015, KLINE was determined to be at maximum medical improvement ("MMI"), stable not ratable, and was released to her full duty with no restrictions. (ROA 490). On November 6, 2015, CITY OF RENO issued a notice of intent to close KLINE's claim. (ROA 295). After an appeal, the Department of Administration concluded that KLINE's industrial claim was closed prematurely. (ROA 239-240).

On January 13, 2016, KLINE saw Dr. Hansen for chiropractic care for her neck pain and Dr. Hansen assessed that KLINE had "cervical disc displacement, unspecified cervical region." (ROA 296-298). Dr. Hansen felt that there was a high probability within a medical degree of certainty that KLINE's injuries were related to the rear-end collision she had recently sustained. (ROA 298, 306, 339). Also, on January 13, 2016, KLINE underwent an MRI, which found disc degeneration with large disc protrusions at the C5-6 and C6-7 levels, resulting in complete effacement of CSF from the ventral and dorsal aspects of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia. (ROA 299, 503). On July 5, 2016, upon Dr. Hansen referral, KLINE saw Dr. Sekhon due to KLINE's ongoing complaints. (ROA 241-246).

On January 18, 2017, the Appeals Officer entered a Decision and Order which reversed claim closure without a PPD evaluation or rating and ordered Respondent, CITY OF RENO to rescind claim closure and provide medical treatment recommended by Dr. Sekhon. (ROA 167-176). CITY OF RENO timely appealed the decision to District Court and Petition for Judicial Review ensued. On December 11, 2017, Judge Simons issued an Order denying the Petition for Judicial Review.

(ROA 373-387). Therein, the Court noted that the Appeals Officer gave the opinions of Dr. Hall no weight as it pertained to the scope of the claims, and that Dr. Hall's opinions were inconsistent with the medical evidence. (ROA 384). That decision was not appealed.

While the Petition for Judicial Review was pending at the District Court, on June 12, 2017, KLINE had a cervical spine decompression and fusion surgery. (ROA 244, 252). On September 11, 2017, KLINE was determined to have reached MMI, was ratable, and was released for full duty. (ROA 248-249). A permanent partial disability ("PPD") evaluation was performed by Dr. Russell Anderson and KLINE was found to have a 25% whole person impairment ("WPI") from the cervical spine, with 75% of the impairment apportioned as non-industrial. (ROA 250-256, 563-564). The self-insured Employer's third-party administrator ("TPA") issued a determination letter on December 5, 2017, offering a 6% PPD award. (ROA 362, 568). KLINE appealed, and a second PPD evaluation was ordered and subsequently conducted by Dr. James Jempsa on May 8, 2018. (ROA 605-616). Dr. Jempsa found KLINE to have a 27% WPI with none of the impairment apportioned as non-industrial. (ROA 616-617). Because apportionment was not considered, the TPA sent a follow up request asking Dr. Jempsa to review Dr. Anderson's PPD evaluation and address apportionment. (ROA 1162). On May 18, 2018, Dr. Jempsa provided an Addendum which stated, "You will need to contact Dr. Anderson concerning his rationale for apportionment . . . the Claimant stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. I have not received any medical records prior to the industrial injury . . . it is my opinion that apportionment is not necessary in this case." (ROA 1171).

On May 24, 2018, due to the large discrepancy between the two PPD ratings, a TPA determination letter notified KLINE that the 27% PPD award was to be held in abeyance pending a records review by Dr. Jay Betz. (ROA 1172). Dr. Betz provided his review and agreed with Dr. Anderson's findings on apportionment noting Dr. Anderson's conclusions "are well supported by the medical record, known pathologies, AMA guides, and Nevada Administrative Code." (ROA 1189). After a records review, the TPA sent a determination letter on June 13, 2018, offering KLINE a PPD award of 6% based on an apportionment of 75% of the WPI as non-industrial. (ROA 618). KLINE appealed this determination and on July 19, 2018, after a hearing, a Hearing Officer Decision was

entered reversing the TPA's determination. (ROA 601-603). CITY OF RENO maintained that apportionment is proper in this case and offered the uncontested 6% as a lump sum or in installments, and under NRS 616C.380, stated it will pay the remaining, contested 21% in monthly installments. CITY OF RENO, the employer, appealed and requested a stay. (ROA 007:6-7).

On May 1, 2019, an Appeal Hearing was conducted and on August 20, 2019, the Appeals Officer Decision and Order was filed. KIMBERLY KLINE's August 28, 2019 Petition for Judicial Review seeks reversal of the August 20, 2019 Appeals Officer Decision which addressed the appeals of three separate Hearing Officer Decisions: AO1900471-RKN, AO1902049-RKN, and AO1802418-RKN. KLINE, however, only petitions for judicial review of the issue on appeal in AO1900471-RKN, which was the Hearing Officer Decision, dated July 19, 2018, reversing the TPA's May 24, 2018 and June 13, 2018 determination letters regarding apportionment of KLINE's PPD award. (See Petition, Ex. 1, Decision of the Appeals Officer ("Decision"); ROA 001-022). KLINE argues that the Appeals Officer's August 20, 2019 Decision prejudices substantial rights of the Petitioner; was affected by error of law; was clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; and was arbitrary and capricious based upon an abuse of discretion by the Appeals Officer.

In this Order, this Court will determine: (1) whether the Appeals Officer's August 20, 2019 Decision which reversed the Hearing Officer's Decision dated July 19, 2018, and affirming the underlying determinations, dated May 24, 2018 and June 13, 2018, was the result of reversible error of law; and (2) whether the Appeals Officer's Decision finding that the Petitioner's PPD award must be apportioned 75% as pre-existing is not supported by substantial evidence and results in an abuse of discretion.

"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." *NRS 233B.135(1)*. "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." Id. "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."

NRS 233B.135(2). "The court shall not substitute its judgment for that of the agency as to the weight of evidence on a question of fact." *NRS 233B.135(3).* "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."
>
> *NRS 233B.135(3).*

Under the standard of review for appeals, if factual findings of the agency are supported by evidence, they are conclusive and reviewing the court's jurisdiction is confined to questions of law. *NRS 612.530(4); NRS 233B.135;* Whitney v. State, Dep't of Employment Sec., 105 Nev. 810, 812 (1989), citing Nevada Employment Sec. Dep't v. Nacheff, 104 Nev. 347, 349 (1988). On appeal, the District Court reviews questions of law, including the administrative agency's interpretation of statutes, de novo. City of N. Las Vegas v. Warburton, 127 Nev. 682, 686 (2011). Review of an Appeals Officer's decision is limited to determining whether there was substantial evidence in the record to support the Appeals Officer's decision and that the findings and ultimate decisions of the Appeals Officer are not disturbed unless they were clearly erroneous or otherwise amounted to an abuse of discretion. Nevada Indus. Comm'n v. Reese, 93 Nev. 115, 125 (1977); State Indus. Ins. Sys. v. Snapp, 100 Nev. 290, 294 (1984); Stark v. State Indus. Ins. Sys., 111 Nev. 1273, 1275 (1995); State Indus. Ins. Sys. v. Hicks, 100 Nev. 567, 569 (1984), State Indus. Ins. Sys, v. Swinney, 103 Nev. 17, 20 (1987); State Indus. Ins. Sys. v. Christensen, 106 Nev. 85, 88 (1990); Brown v. State Indus. Ins. Sys., 106 Nev. 878, 880 (1990); Maxwell v. State Indus. Ins. Sys., 109 Nev. 327, 331 (1993).

The review of the District Court is confined to the record and the court is precluded from substituting its own judgment for that of the agency as to the weight of the evidence on questions of fact. Nevada Indus. Comm'n v. Williams, 91 Nev. 686, 688 (1975); State Indus. Ins. Sys. v. Swinney, 103 Nev. 17, 19-20 (1987); Palmer v. Del Webb's High Sierra, 108 Nev. 673, 686 (1992). The Court's review is limited to a determination of whether the Appeals Officer acted arbitrarily or capriciously, and where there was substantial evidence to support the decision, the Court cannot

substitute its own judgment for that of the Appeals Officer. Construction Indus. Workers' Comp. Group v. Chalue, 119 Nev. 348, 352 (2003); Meridian Gold Co. V. State, 119 Nev. 630, 633 (2003); State v. Public Employees' Ret. Sys., 120 Nev. 19, 23 (2004).

An "agency's fact-based conclusions of law 'are entitled to deference, and will not be disturbed if they are supported by substantial evidence.'" Law Offices of Barry Levinson, P.C. v. Milko, 124 Nev. 355, 362 (2008). "Substantial evidence exists if a reasonable person could find the evidence adequate to support the agency's conclusion, and [the Court] may not reweigh the evidence or revisit an appeals officer's credibility determination." Id.; *NRS 233B.135(4).* "While it is true that the district court is free to decide pure legal questions without deference to an agency determination, the agency's conclusions of law, which will necessarily be 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 (1986).

CITY OF RENO contends that the appealed issue is a mixed question of law and fact entitled to deference; a question of law as to whether the Appeals Officer correctly interpreted NRS 616C.490(9) and NAC 616C.490 with respect to apportionment, and of fact, as the Appeals Officer was required to apply the facts to the law. CITY OF RENO argues that KLINE is requesting this Court substitute its opinion for that of the Appeals Officer's as to the application of the evidence to the law and contends that to do so is impermissible.

Petitioner, KIMBERLY KLINE argues that reversal of the Appeals Officer's August 20, 2019 Decision is required because the decision is procedurally deficient and the result of reversible error. KLINE argues that the Appeals Officer committed reversible error in two areas: (1) the Appeals Officer relitigated facts which she previously decided in a prior appeal, and (2) the Appeals Officer did not correctly apply NAC 616C.490 and NRS 616C.490. KLINE also argues that the Appeals Officer's Decision is erroneous in view of the reliable, probative, and substantial evidence on the whole record and results in an abuse of discretion.

KLINE argues that the Appeals Officer's Decision relied on the opinions of Dr. Hall which the Appeals Officer previously determined to be not credible, inconsistent with the medical records, and were not stated within a reasonable degree of medical probability. (ROA 174:8-10). KLINE

argues that since the Appeals Officer gave little or no weight to the opinions of Dr. Hall, it is reasonable to conclude that any subsequent opinion by a rating physician should also be bound by those findings. KLINE argues that the Appeals Officer failed to consider her prior findings and conclusions, therefore her August 20, 2019 Decision is based on faulty information.

KLINE also argues that substantial evidence on the record establishes that she did not have a pre-injury impairment under the AMA Guides, 5th Edition. Specifically, KLINE notes the Appeals Officer previously found that Dr. Hansen stated that there was a high probability within a degree of medical certainty that KLINE's injuries were related to the car accident. (ROA 170:23-28). Dr. Hansen opined that the "MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision." (ROA 306). KLINE asserts that the Appeals Officers found that "substantial evidence supports a finding that the industrial accident aggravated the pre-existing condition and that the resulting conditions was the substantial contributing cause of the resulting condition." (ROA 174:6-8). KLINE argues that apportioning the rating by 75% when it had already been determined that the industrial injury was the substantial contributing factor for the resulting condition is inconsistent with the Appeals Officer's prior decision. Therefore, KLINE asserts that the Appeals Officer committed reversible error of law by re-litigating those facts which she previously decided in a prior appeal.

CITY OF RENO, however, argues that KLINE's argument ignores the fact that the question on appeal in the earlier decision was whether claim closure without a PPD rating was proper. (ROA 167:18-23). CITY OF RENO asserts that Dr. Hansen's statement about KLINE's injuries being related to the car accident, and the Appeals Officer's finding that KLINE had "met her burden of proof with substantial evidence that she is not at maximum medical improvement and needs further treatment" required the claim to remain open. (ROA 174:11-12). Thus, the earlier decision, CITY OF RENO contends, makes no findings as to the propriety of apportionment, as the January 18, 2017 Appeals Officer Decision contemplated a possible future PPD evaluation once KLINE had completed treatment and was determined stable. (ROA 174:18-19).

///

CITY OF RENO asserts that in the prior decision the Appeals Officer gave more weight to Dr. Sekhon's and Dr. Hanson's medical opinions, and less weight to Dr. Hall's opinion that KLINE did not suffer a ratable impairment. CITY OF RENO argues that the Appeals Officer's decision to give Dr. Hall's opinion no weight is not binding on future rating physicians, as the prior decision pre-dated the spinal fusion surgery, and the PPD evaluations by Dr. Anderson and Dr. Jempsa, as well as Dr. Betz's records review report and expert testimony, upon which the Appeals Officer specifically relied in reaching the Decision at issue here.

The Appeals Officer also gave Dr. Jempsa's PPD evaluation no weight because there was a large discrepancy in Dr. Jempsa's range of motion findings which made his results questionable as "[i]t is well recognized that patients learn from prior rating experience." (ROA 017:16-17, 018:12-18, 1192). Dr. Jempsa failed to apportion because KLINE stated she had no problems with her neck prior to the industrial injury and because he had received no records prior to the industrial injury on June 25, 2015, which the Appeals Officer found was not required under NAC 616C.490. (ROA 018:3-12). The Appeals Officer concluded that Dr. Jempsa's findings were also questionable because "the medical evidence depicts stenosis, spondylitis, and osteophytes which take years if not decades to form." (ROA 018:12-14).

The Appeals Officer based the decision upholding apportionment primarily on the medical evidence from Dr. Anderson and Dr. Betz, whom she "found to be credible and their opinions given the most weight." (ROA 007:19-20, 013:25-26, 014:1-2). Although Dr. Betz testified that Dr. Hall "was probably correct that the [Claimant] suffered a sprain/strain," and that she did eventually improve "as would be expected with a . . . sprain/strain," Dr. Betz testified that there was not "any significant relationship" between those symptoms and the degenerative disc disease findings on KLINE's MRI results. (ROA 055:11-17, 056:1-2). Dr. Betz testified that the reason it took KLINE seven months to improve from the sprain/strain was because "there was unrecognized underlying multilevel degenerative disc changes." (ROA 055:18-23).

While it is true that Dr. Betz's report notes that Dr. Hall's opinion supports Dr. Anderson's conclusion that KLINE's cervical spine pathologies were primarily degenerative in nature and pre-existing, the Appeals Officer Decision does not rely on Dr. Hall's opinion alone. (ROA 011).

Moreover, regardless of whether Dr. Betz relied on Dr. Hall's opinion, what is at issue here is KLINE's pain and additional treatment related to the pre-existing degenerative condition which began after she had recovered from the industrial sprain/strain and was released by Dr. Hall. Dr. Betz's record review report and extensive expert testimony make clear that he considered all medical reporting and imaging studies in reaching his conclusion that the medical evidence establishes that KLINE had a pre-existing condition. (ROA 011-013).

CITY OF RENO argues that Dr. Betz's opinion incorporating Dr. Hall's opinion and his reliance on Dr. Hall's reporting was not inconsistent with the Appeals Officer's prior decision and that the prior decision does not preclude the Appeals Officer from taking that subsequent medical history and documentation into consideration when reaching decisions. In view of all the medical evidence, much of which did not exist at the time of the prior decision relied on by KLINE, the Appeals Officer properly concluded that KLINE had a pre-existing condition mandating apportionment of impairment under NAC 616C.490. This presents a new question of law not previously addressed by the Appeals Officer and which requires a separate and distinct legal analysis and application of the medical evidence than that performed in the prior decision. Thus, CITY OF RENO argues and the Court finds that the prior decision concluding that the industrial injury aggravated a pre-existing condition under NAC 616C.175(1), makes the present decision upholding apportionment based on substantial medical evidence establishing that KLINE had a pre-existing cervical spine condition consistent with the law of the case. The Court finds the Appeals Officer Decision, dated August 20, 2019, was not the result of reversible error nor an abuse of discretion as the Appeals Officer did not re-litigate facts previously decided in a prior appeal and the Decision is supported by substantial evidence.

KLINE also argues that the Appeals Officer erred by not complying with the mandates of NRS 233B.125. NRS 233B.125 states:

> "A decision or order adverse to a party in a contested case must be in writing or stated in the record. Except as provided in subsection 5 of NRS 233B.121, a final decision must include findings of fact and conclusions of law, separately stated. Findings of fact and decisions must be based upon a preponderance of the evidence. Findings of fact, if set forth in statutory language, must be accompanied by a concise and explicit statement of the underlying facts supporting the findings. If, in accordance with

> agency regulations, a party submitted proposed findings of fact before the commencement of the hearing, the decision must include a ruling upon each proposed finding. Parties must be notified either personally or by certified mail of any decision or order. Upon request a copy of the decision or order must be delivered or mailed forthwith to each party and to the party's attorney of record."

NRS 233B.125.

The Court finds the Appeals Officer decision included findings of fact and conclusions of law, separately stated. In addition, the Court finds the Appeals Officer's findings of fact and decision are based upon a preponderance of evidence, and the Appeals Officer enumerated each of the facts underlying those findings.

In addition, KLINE argues that the Appeals Officer committed reversible error by not correctly apply NRS 616C.490 and NAC 616C.490. KLINE argues that NRS 616C.490 requires that there be evidence that a ratable impairment, as defined by the AMA Guides, existed on the date of the industrial injury for apportionment to occur. KLINE argues there is no prior medical records confirming that there was a ratable impairment, prior residual impairment, and proof of a residual impairment which existed on the date of the industrial injury and that Dr. Jempsa, after reviewing numerous prior records predating KLINE's industrial injury, found apportionment was not appropriate. (ROA 617). KLINE asserts that Dr. Betz conceded that there is no documentation concerning the scope and nature of the impairment which existed before the industrial injury. (ROA 087, 088, 094). Thus, KLINE contends that at the time of the industrial injury, she had a 0% impairment due to any pre-existing condition that she may have had, and therefore, the impairment may not be apportioned.

NRS 616C.490 states: "Except as otherwise provided in subsection 10, if 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 there from the percentage of the previous disability as it existed at the time of the subsequent injury." *NRS 616C.490(9)* [effective through December 31, 2019]; Pub. Agency Comp. Tr. (PACT) v. Blake, 127 Nev. 863, 867 (2011) (holding calculations for prior and subsequent injuries when impairment ratings for those injuries were based on different editions of the applicable guide, be reconciled by first using the current edition of the AMA Guides to determine both the percentage of the entire disability and of the previous disability).

The Nevada Administrative Code provides the procedure for completing apportionment. *See NAC 616C.490.* The Administrative Code requires a precise apportionment to be completed "if a prior evaluation of the percentage of impairment is available and recorded for the pre-existing impairment." *NAC 616C.490(3).* However, the Administrative Code specifically contemplates the situation here, where there is no prior rating evaluation of the pre-existing condition. In such a case, the Administrative Code provides in pertinent part that:

> 4. Except as otherwise provided in subsection 5, . . . 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.

NAC 616C.490(4)-(5).

"If there are preexisting conditions . . . 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." *NAC 616C.490(6).* CITY OF RENO argues that NAC 616C.490 does not require that the documentation of a pre-existing condition predate the industrial injury. In Ransier v. State Industrial Insurance Systems, the Nevada Supreme Court stated that "the clause 'which existed before the industrial injury or the onset of the disease' refers to the impairment and not the document." Ransier v. State Indus. Ins. Sys., 104 Nev. 742, 744 at fn. 1 (1988). Although the reference to this regulation is from the prior version, NAC 616.650(6), the language has remained the same. The Ransier Court held that the Nevada Administrative Code "does not require historical documentation, only 'documentation concerning the scope and nature of the impairment,' which can come, as here, from examination at the time of the second injury." Id. (affirming apportionment was proper where no records or documents existed concerning claimant's prior injury, but where both treating physicians found claimant's two injuries to be distinguishable).

CITY OF RENO also argues that the Appeals Officer correctly interpreted NRS 616C.490 and NAC 616C.490 in finding apportionment does not require that the pre-existing condition be a ratable impairment. Rather, CITY OF RENO argues that the rating physician must look for a prior impairment, shown by medical records post-dating the industrial injury. CITY OF RENO argues that KLINE incorrectly insists that apportionment for a pre-existing disease or condition requires a "ratable" impairment to have existed on the date of the industrial accident. "[W]hen the language of a statute is plain and unambiguous, a court should give that language its ordinary meaning and not go beyond it." Nev. Dep't of Corr. v. York Claims Servs., Inc., 131 Nev. 199, 203 (2015). CITY OF RENO argues that the plain language of NAC 616C.490 simply requires an "impairment" with no requirement that the pre-existing condition or disease be previously rated.

"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." *NAC 616C.490(7)*. Here, the Appeals Officer found "Dr. Betz to be a credible witness and his testimony is given great weight. Dr. Betz's testimony was uncontroverted at [the] hearing and no opposing or contradicting expert witness testimony was provided." (ROA 007:19-21). Based on the records from Dr. Sekhon, who performed KLINE's spinal fusion surgery, in addition to MRI, x-ray records, and historical records and diagnoses, demonstrating the scope and nature of the impairment, Dr. Betz testified that the present impairment was at least fifty percent (50%) due to KLINE's pre-existing impairment. (ROA 15:24-27, 16:1-10). The Appeals Officer concluded that Dr. Betz and Dr. Anderson established the underlying basis for apportionment as required by NAC 616C.490(5)-(7). (ROA 16:10-15). CITY OF RENO argues and the Court finds that KLINE's contention that apportionment is improper due to a lack of prior documentation of the pre-existing, ratable condition is unpersuasive where the Appeals Officer found Dr. Betz has expressly identified the x-rays, historical records, and diagnoses confirming KLINE's prior impairment as required by NAC 616C.490(5).

Following review of the Appeals Officer's Decision, the Court finds the Appeals Officer did not commit any clear error of law nor arbitrary or capricious abuse of discretion. As discussed supra, the Court finds the Appeals Officer correctly applied NRS 616C.490 and NAC 616C.490. In

addition, the Court finds the Decision is supported by substantial evidence and the Appeals Officer's findings of fact and conclusions of law in the Decision complied with the requirements set forth in NRS 233B.125. KLINE was properly awarded 6% PPD award, which apportioned 25% WPI of the cervical spine as 75% non-industrial and 25% industrial. Therefore, the Court finds there is no basis to grant review and the Petition should be denied.

Based on the foregoing and good cause appearing,

IT IS HEREBY ORDERED that KIMBERLY KLINE's Petition for Judicial Review is DENIED and the decision of the Appeals Officer, dated August 20, 2019, is AFFIRMED.

DATED this 10 day of February, 2021.

Connie J. Steinheimer
DISTRICT JUDGE

CERTIFICATE OF SERVICE

CASE NO. CV19-01683

I certify that I am an employee of the SECOND JUDICIAL DISTRICT COURT of the STATE OF NEVADA, COUNTY OF WASHOE; that on the 10 day of February, 2021, I filed the **ORDER DENYING PETITION FOR JUDICIAL REVIEW** with the Clerk of the Court.

I further certify that I transmitted a true and correct copy of the foregoing document by the method(s) noted below:

_____**Personal delivery to the following: [NONE]**

xx **Electronically filed with the Clerk of the Court, using the eFlex system which constitutes effective service for all eFiled documents pursuant to the eFile User Agreement.**

TIMOTHY ROWE, ESQ. for CANNON COCHRAN MANAGEMENT SERVICES, CITY OF RENO

LISA ALSTEAD, ESQ. for CANNON COCHRAN MANAGEMENT SERVICES, CITY OF RENO

HERBERT SANTOS, JR., ESQ. for KIMBERLY M KLINE

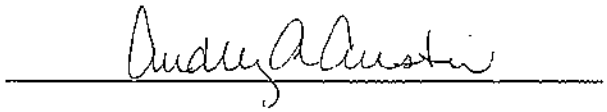
_____**Transmitted document to the Second Judicial District Court mailing system in a sealed envelope for postage and mailing by Washoe County using the United States Postal Service in Reno, Nevada: [NONE]**

_____**Placed a true copy in a sealed envelope for service via:**

_____ Reno/Carson Messenger Service – **[NONE]**

_____ Federal Express or other overnight delivery service **[NONE]**

DATED this 10 day of February, 2021.



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Clerk of the Court
Transaction # 8331955

CASE NO. CV19-01683 **TITLE: KIMBERLY KLINE VS. CITY OF RENO and CANNON COCHRAN MANAGEMENT SERVICES**

DATE, JUDGE OFFICERS OF COURT PRESENT	APPEARANCES-HEARING	CONT'D TO
11/19/2020 HONORABLE CONNIE STEINHEIMER DEPT. NO.4 M. Stone (Clerk) J. Schonlau (Reporter)	**ORAL ARGUMENTS ON PETITION FOR JUDICIAL REVIEW** Petitioner, Kimberly Kline, appearing from Washoe County, Nevada, being represented by Herbert Santos, Jr., Esq., appearing from Washoe County, Nevada. Lisa Alstead, Esq., appearing from Washoe County Nevada, represented the Respondents, City of Reno and Cannon Cochran Management Services. This hearing was held remotely because of the closure of the courthouse at 75 Court Street in Reno, Washoe County, Nevada due to the National and Local emergency caused by COVID-19. The Court and all the participants appeared via simultaneous audiovisual transmission. The Court was physically located in Reno, Washoe County, Nevada which was the site of the court session. Counsel acknowledged receipt of Notice that the hearing was taking place pursuant to Nevada Supreme Court Rules- Part 9 relating to simultaneous audiovisual transmissions and all counsel stated they had no objection to going forward in this manner. Petition for Judicial Review by Petitioner's counsel; presented argument; objection and argument by Respondent counsel; reply argument by Petitioner's counsel. **COURT** will take Petition for Judicial Review under advisement once the transcript of these proceedings has been filed with the Court. Court recessed.	

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IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO, and the NEVADA DEPARTMENT OF ADMINISTRATION APPEALS OFFICER,

Respondents.

Case No.: CV19-01683

Dept. No.: 4

PETITIONER'S REPLY BRIEF

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TABLE OF AUTHORITIES

COMES NOW the Petitioner, KIMBERLY KLINE, by and through her attorney, HERB SANTOS, JR., Esq., of THE LAW FIRM OF HERB SANTOS, JR., and hereby respectfully submits her ***Petitioner's Reply Brief*** in the above referenced matter.

Respectfully submitted this 22 day of May, 2020.

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I. LEGAL ANALYSIS.

1. THE SUBSTANTIAL EVIDENCE COUPLED WITH THE PRIOR CONCLUSIVE FINDINGS IN AO 56832-RKN BY THE SAME APPEALS OFFICER RENDERS HER DECISION SUSPECT, IS AFFECTED BY ERRORS OF LAW, IS CLEARLY ERRONEOUS IN VIEW OF THE RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE ON THE WHOLE RECORD AND CAN ONLY BE CHARACTERIZED AS THE PRODUCT OF AN ABUSE OF DISCRETION.

The Respondent emphasizes the correct regulation yet somehow ignores the rule in its analysis. Under NAC 616C.490(4), the rating doctor,

> 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.** [Emphasis added.]

It is well settled that the Legislature 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); ***Public Agency Compensation Trust v. Blake,*** 127 Nev. 863, 868 (2011). According to Dr. Betz, who was the hired expert for the Respondent, there was precise information to determine the pre-existing condition. Dr. Betz had the Claimant's prior records and post industrial accident records. ***ROA 044.*** The Claimant had been in a prior work related accident yet had no complaints of neck pain. Dr. Betz testified regarding the prior work related accident as follows:

> "Well, there was no justification for obtaining spine-cervical spine imaging at the time she saw Dr. Menure." ***ROA 045.***

Dr. Betz also confirmed that there was precise information to determine the pre-existing condition.

AA 0081

LISA ALSTEAD: In performing a records review and examining pre-existing conditions, can you rely on MRIs or scans that are performed after the injury, to give you a basis for a pre-existing condition?

DR. JOHN BETZ: Sure. Sure. ***ROA 046.***

Dr. Betz then was asked by Respondent's counsel a hypothetical question as to what type of rating would he give the Claimant based on Dr. Hall's records relevant to treatment of the industrial condition. ***ROA 049.*** Dr. Betz opined that the rating would be a 0%. ***ROA 050.*** On cross examination, Claimant's counsel attempted to ask a hypothetical question, in fact it was the first question asked, and the Appeals Officer advised:

> Mr. Santos, I'm not interested in hypotheticals; if you have questions specific to this Claimant, please proceed. ***ROA 071.***

When asked whether he could apportion what pain was related to the Claimant's degenerative changes versus what was caused by the CS/6, C6/7 herniations which were causing cord compression, Dr. Betz advised that he could not do that. ***ROA 083.*** Dr. Betz then conceded that there was no medical evidence that the Claimant had any ratable impairment to her cervical spine before the industrial injury. ***ROA 087.*** He also conceded that there was no evidence that the Claimant's pre-exiting cervical condition was symptomatic at any time prior to the industrial injury. ***ROA 098.*** In fact Dr. Betz testified that:

> **Thats correct. No evidence of a ratable impairment. She clearly had an impairment, but not a ratable one.** ***ROA 087.*** ***[Emphasis added.]***

Finally, Dr. Betz was asked the following question:

HERB SANTOS: Would it be fair to say that Dr. Jempsa's opinion would be correct on apportionment if the disc protrusions were caused by the motor

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vehicle?

DR. JOHN BETZ: (laughs) well, if red is determined is blue, then I guess so, but -

HERB SANTOS: That's all I have, thank you Doctor.

APPEALS OFFICER: Let him finish his answer.

DR. JOHN BETZ: Okay

APPEALS OFFICER: Finish your answer, Dr. Betz, please.
DR JOHN BETZ: I think that question [inaudible] ridiculous but if there-if it was proven somehow- proven somehow that all the patient's cervical pathologies, all the spurring, the osteophytes, the bulging, the spondylolisthesis, the spondylosis, they're all related to that incident, which is preposterous, then yes, he's correct.

HERB SANTOS: I'm asking about the disc protrusions, if those two disc protrusions that were causing nerve compression on the spinal cord, if that was deemed to be-if you have to accept that as true, that that was industrial, then Doctor, you would have no issues with-and based upon the fact that there were no prior records or anything, you would be-you would agree with Dr. Jemsa's final conclusion regarding apportionment, is that fair?

LISA ALSTEAD: Objection, Your Honor. Compound question and asked and answered.

APPEALS OFFICER: Let's-let's wrap this up. That is compound question and it has been asked.

ROA 106-107.

If the Claimant had no ratable impairment, it is outrageous to then apportion a rating 75% due to a pre-existing condition. Especially given the fact that the aggravation of the Claimant's pre-existing degenerative changes was **NOT** the substantial contributing cause of her resulting condition. It is set by statute that under NRS 616C.175 a pre-existing condition that is aggravated by an industrial injury is only deemed not industrial if there is evidence that the resulting condition was

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substantially caused by the pre-existing condition. ***NRS 616C.175(1)***. The rule states as follows:

> 1. The resulting condition of an employee who:
> (a) Has a preexisting condition from a cause or origin that did not arise out of or in the course of the employee's current or past employment; and
> (b) Subsequently sustains an injury by accident arising out of and in the course of his or her employment which aggravates, precipitates or accelerates the preexisting condition,
> shall be deemed to be an injury by accident that is compensable pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS, unless the insurer can prove by a preponderance of the evidence that the subsequent injury is not a substantial contributing cause of the resulting condition.

The Appeals Officer already ruled and found that the pre-exisitng condition was not a substantial contributing cause of the resulting condition. How then could any reasonable factfinder conclude that 75% apportionment is not substantial. The Appeals Officer essentially already made the specific finding that Dr. Hansen, after reviewing the MRI, opined that the

> "MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision." ***ROA 173***.

In the prior AO 56832-RKN, the Appeals Officer specifically found that

> the conditions claimed by the Claimant are casually related to the subject industrial accident. This conclusion is supported by the medical evidence and the medical opinions of Dr. Hansen and Dr. Sekhon. ***ROA 174***.

Dr. Betz concedes that if the two disc herniations were caused by the industrial accident, then Dr. Jempsa's PPD conclusion was correct. ***ROA 106***. Dr. Jempsa also correctly determined that apportionment was not appropriate under the ***AMA Guides*** because

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she had no prior impairment or issues.

The Appeals Officer's decision is entirely based upon her accepting the opinion of Dr. Betz who never physically examined or treated the Claimant or performed a PPD examination on her. Since Dr. Betz' opinions, which are in part made upon the reporting of Dr. Hall, are based upon faulty information which this Appeals Officer found to be unreliable and disregarded. How then can the Appeal's Officer not commit an abuse of discretion if she accepts an opinion that is based upon medical evidence the Appeals Officer already concluded was not reliable? Clearly this is an abuse of discretion and violates the very essence of res judicata or issue preclusion.

The Respondent submits that NAC 616C.490 was properly applied by Dr. Anderson and that the none of the conclusive facts were mischaracterized. A review of the Respondent's "clarification" merely further supports the Claimant's position.

FACT 1. The full answer given by the Respondent only confirms that Dr. Betz could not determine what was disc related, what was facet related, how much was ligament related. For apportionment, that is the requirement. Determining what was caused by the industrial accident. Dr. Betz conceeded that he could not make that determination.

FACT 2. No question that Dr. Betz only agreed to the hypothetical that if the discs were found to be caused by the industrial accident, his opinion would be different. That was exactly what the Claimant stated in her opening brief. **IF** the C5/6 and C6/7 protrusions were caused by the industrial accident, it would change his opinion on apportionment. Respondent

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confirms its expert's position with the additional clarification. The Respondent also identifies an additional error in that the Appeals Officer found that there was no acute pathologies on the MRI. ***Answering Brief page 19, line 21.*** There was no cervical MRI because the work comp doctor where the Claimant was ordered to go at the beginning of the claim did not order one. The cervical MRI was done 7 months after the accident after she received limited treatment from Specialty Health Clinic which is the designated clinic for work comp injuries for the City of Reno. The Appeals Officer's decision clearly confused the July 5, 2016 report as occurring at the time shortly after the June 25, 2015 industrial car accident. The Respondent then confirms that the Appeals Officer found it significant that there was no evidence that the Claimant had symptoms or examination findings of a neck injury at the time of her initial presentation to the ER. ***Answering Brief, page 19, line 18.*** This statement is incredible given the Appeals Officer's prior findings of fact and the fact that notwithstanding the medical records, the Claimant complained of neck pain at the ER. A review of the C-4 which is a document in her writing, clearly states that she hurt her mid back and neck. ***ROA 257.*** The C-4 was completed by the Claimant on the day of the accident. A review of the C-1 also in her own handwriting, states neck pain. ***ROA 258.*** This is what the evidence consisted of for cervical complaints after the accident which were findings of the Appeals Officer in AO 56832-RKN:

> On June 30, 2015, the Claimant presented to Dr. Hall at Specialty Health. The Claimant had complaints of neck discomfort that was described as moderate, diffuse, radiating into the right shoulder with associated stiffness and lumbar and thoracic pain described as diffuse, with no

red flags, no numbness or weakness in the legs. Dr. Hall assessed the Claimant suffered a sprain of the neck and sprain of the lumbar region, recommended chiropractic care, returned the Claimant to work full duty, and advised her to return in two weeks. *Exhibit 4, pages 22-25.* ***ROA 169.***

The Claimant presented to Dr. Brady for chiropractic care on July 1, 2015. Dr. Brady assessed that the Claimant had spinal segment dysfunction at C6, C7, T1, T3, T4, L4, L5 and S1 that necessitated chiropractic adjusting at those levels. *Exhibit 3, pages 5-8.* The Claimant saw Dr. Brady again on July 7, 2015 and July 9, 2015 with complaints of worsening symptoms. Dr. Brady provided chiropractic adjustments. *Exhibit 3, pages 9-16.* ***ROA 169.***

The Claimant returned to see Dr. Hall on July 14, 2015. The Claimant continued to have ongoing lumbar and neck pain, that was moderate to severe, associated sleep disruption and stiffness, and had minimal improvement with chiropractic care. Dr. Hall recommended the Claimant have six physical therapy sessions. *Exhibit 4, pages 51-53.* ***ROA 169.***

On July 23, 2015, the Insurer accepted the Claimant's claim for a cervical strain. *Exhibit 4, page 59.* ***ROA 169.***

The Claimant began physical therapy on August 5, 2015 with P.T. Bruesewitz. P.T. Bruesewitz's assessment was lumbosacral strain/sprain with pain and decreased range of motion as well as cervical sprain/strain with pain. *Exhibit 3, pages 24-26.* The Claimant continued physical therapy treatment on August 11th, 18th, and 20th, 2015. *Exhibit 3, pages 27-29.* ***ROA 169.***

The Claimant returned to see Dr. Hall on August 20, 2015. Dr. Hall noted that the Claimant reported improvement in her neck symptoms with only mild muscular tightness, and that physical therapy had been helpful. Dr. Hall recommended that the Claimant finish her physical therapy and to keep him advised as to her physical status. *Exhibit 4, pages 74-75.* ***ROA 169.***

The Claimant returned to physical therapy on August 25, 2015 with complaints of pain in her neck and low back that was less consistent and not as intense, neck tightness that came and went, as well as low back pain/pressure. *Exhibit 3, pages 30-31.* ***ROA 169-170.***

The Claimant had additional physical therapy sessions with P.T. Bruesewitz on September 1st, 3rd, 10th, 14th, 21st, and 23rd, 2015 for her low back and neck complaints. *Exhibit 3, pages 32-37.* ***ROA 170.***

The Claimant presented to Dr. Hall on September 23, 2015. The Claimant reported improvement in her neck discomfort. Dr. Hall recommended a recheck in two weeks.

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Exhibit 4, pages 82-84. On September 29, 2015, the Claimant was re-evaluated by P.T. Bruesewitz. The Claimant reported that she had a flare-up and began to have increased pain, tightness and spasms in the right neck and upper trapezious area. The Claimant had significant tightness with decreased right rotation of the neck. P.T. Bruesewitz recommended additional physical therapy twice per week for five weeks. *Exhibit 3, pages 38-43.* ***ROA 170.***

The Insurer issued a letter rescinding claim closure on October 1, 2016. *Exhibit 4, page 85.* ***ROA 170.***

P.T. Bruesewitz noted that the Claimant felt her neck was a little better but still tight on the right side at her therapy visit on October 5, 2015. The Claimant completed physical therapy on October 7th, 12th, 14th, 21st, and 26th, 2015. The Claimant was discharged from physical therapy on October 26, 2015 to a home exercise program. *Exhibit 3, pages 44-49.* ***ROA 170.***

On October 28, 2015, the Claimant was again seen by Dr. Hall. He noted that the Claimant had no neck symptoms and that she had completed treatment. *Exhibit 4, pages 95-97.* ***ROA 170.***

On January 13, 2016, the Claimant saw Dr. Hansen for chiropractic care for her neck pain. Dr. Hansen's assessment was that the Claimant had cervical disc displacement, unspecified cervical region. Dr. Hansen noted that the Claimant was involved in two motor vehicle accidents which resulted in workers' compensation treatment for neck and shoulder pain. Dr. Hansen felt that there was a high probability within a medical degree of certainty that the Claimant's injuries were related to the rear-end collision she had recently sustained. Dr. Hansen recommended non-surgical spinal decompression coupled with Class IV deep tissue laser therapy four (4) times per week for four (4) weeks, undergo re-examination, and continue with care at two (2) times a week for two (2) weeks pending no unforseen issues or conditions. Dr. Hansen also recommended the Claimant undergo a MRI. *Exhibit 4, pages 118-120.* The Claimant had the MRI on January 13, 2016, which revealed disc degeneration with large disc protrusions at the C5-6 and C6-7 levels resulting in complete effacement of CSF from the ventral and dorsal aspects of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia. *Exhibit 1, page 1.* ***ROA 170-171.***

The Claimant returned to see Dr. Hansen for twenty (20) visits from January 15, 2016 through March 16, 2016. The Claimant continued to suffer from her C5-6 and C6-7 disc injury that caused severe left arm and forearm pain with numbness in the forearm and first two digits. ***ROA 171.***

Finally, the Appeals Officer held that

> I find that the testimony of the Claimant was very credible. I also found the opinions of Dr. Sekhon and Dr. Hansen to be well reasoned. I specifically give more weight to the opinions of Dr. Sekhon and Dr. Hansen as opposed to Dr. Hall as the objective medical evidence supports Dr. Sekhon's and Dr. Hansen's medical expert opinions. ***ROA 172.***

The Appeals Officer disregarded all of her prior findings of fact and found it significant that there were no neck complaints at the time of the initial ER visit. As shown in the C-4, this is wrong. Coupled with the Claimant's testimony during the first appeal hearing, which the Appeals Officer found to be credible, that she hurt her neck, renders her statement that there were no complaints of neck pain as evidence of an abuse of discretion as that point somehow provides support for Dr. Betz's opinion. ***ROA 263.***

Interestingly the Respondent did not accept the lumbar spine but rather the cervical when they issued their claim acceptance letter. ***ROA 208.*** Yet now they take the position that 75% of the Claimant's impairment was due to pre-existing conditions with no evidence of any prior surgical recommendations and no evidence of a prior cervical MRI.

As to Facts 3,4,5 and 6, the Respondent does not dispute those statements. Rather, the Respondent attempts to legitimize the incorrect application of the Nevada regulations and the ***AMA Guides, 5th Edition.*** The Respondent incorrectly states that NAC 616C.490 "does not require that the pre-existing condition be a ratable impairment, or that the medical records evincing the pre-existing condition predate the industrial injury." ***Answering Brief, page 10, lines 8-9.*** The Respondent then simply ignores

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Section 4 of NAC 616C.490. Section 4 states:

> 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.**

When apportioning a rating, the rating doctor must proceed step by step as follows:

1. Is there a prior rating? If yes, apportion the prior rating. NAC 616C.490(3).
2. Is there a prior rating from another state? If yes did they use the ***AMA Guides, 5th Edition***? If yes, apportion that finding. NAC 616C.490(4).
3. If the prior rating from another state used another method, the rater must rate the impairment from the records using the ***AMA Guides, 5th Edition***. NAC 616C.490(4).
4. If there was no prior rating then you rate the pre-existing condition pursuant to the ***AMA Guides, 5th Edition*** based upon the records of the pre-existing condition. NAC 616C.490(4).
5. If precise information is not available, and the rater is unable to rate the pre-existing condition, an

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apportionment may be allowed if at least 50% of the total present impairment is due to a pre-existing condition. NAC 616C.490(5).

6. If there are preexisting conditions, the apportionment must be supported by documentation concerning the scope and the nature of the impairment which existed before the industrial injury. NAC 616C.490(6)

7. If no documentation exists pursuant to subsection 6 or 7, the impairment may not be apportioned. NAC 616C.490(8).

First, the prior impairment was a 0% per Dr. Betz. The Respondent does not dispute this.

Second, there was not one prior record that supported that the Claimant had a cervical impairment prior to the industrial accident. The Respondent does not dispute this.

Last, Dr. Betz could not provide any opinion as to the scope and nature of the impairment. The Respondent does not dispute this.

The Respondent ignores Section 4 of NAC 616C.490 and then mischaracterises the apportionment regulation by stating that the absence of symptoms prior to an industrial accident does not preclude apportionment under NAC 616C.490. Where does it say that? The purpose is to apportion any prior pre-existing condition that caused an impairment. The ramifications of the Respondent's position, and if the Appeals Officer's decision stands, would be completely inconsistent with the ***AMA Guides***. If an injured worker lost his big toe due to a traumatic crushing injury but had diabetes, would Dr. Betz be hired to testify that

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the worker would have probably lost the toe to diabetes at some point in his lifetime so we have to apportion the rating 50-75% because people with diabetes have circulation problems? The potential harm to injured workers based upon this unsupportable position is not supported by Nevada law or the ***AMA Guides***. The intent is to deduct prior pre-existing impairments. Period.

Next, the Respondent alleges that the Appeals Officer never found that the discs were industrially caused. ***Answering Brief, page 18, lines 8-12.*** In order for the Respondent to salvage their position, they have to make that allegation. It is wrong though. The Appeals Officer made the following findings of fact and conclusions of law:

> The Claimant continued to suffer from her C5-6 and C6-7 disc injury that caused severe left arm and forearm pain with numbness in the forearm and first two digits. ***ROA 171.***

Note that the Appeals Officer did not say pre-existing C5-65 and C6-7 but rather referred to them as a C5-6 and C6-7 "**INJURY.**" The only "**INJURY**" was the "**INDUSTRIAL INJURY.**"

The Appeals Officer found that

> She was seen by Dr. Hansen who evaluated her and opined that "there was a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear end motor vehicle collision." ***ROA 173.***

She then held that

> The Claimant has met her burden of proof with substantial evidence that she is not at maximum medical improvement and needs further treatment. Without evidence of a subsequent injury, I find that it is the conditions claimed by the Claimant are casually related to the subject industrial accident. This conclusion is supported by the medical evidence and the medical opinions of Dr. Hansen and Dr. Sekhon. ***ROA 174.***

It is clear from the record that Dr. Hansen opined that the C5-6 and C6-7 disc were caused by the industrial accident and Dr.

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Sekhon opined that the stenosis was aggravated by the industrial accident. ***ROA 173.***

Finally, the Appeals Officer's reliance on the opinions of Dr. Betz and Anderson ignores the fact that their opinions are based upon the opinions of Dr. Hall which the Appeals Officer already found to be unreliable. That in and of itself is an abuse of discretion. The Appeals Officer's opinion that the pre-existing conditions of the Claimant would have formed over years, if not decades is suspect. The Claimant was only 35 years old at the time of the industrial accident with no evidence of prior cervical symptoms. The Respondent's statement that credibility cannot be disturbed on appeal is not entirely accurate. The ***Levinson*** case states the rule that

> Substantial evidence exists if a reasonable person could find the evidence adequate to support the agency's conclusion, and we may not reweigh the evidence or revisit an appeals officer's credibility determination. ***Law Offices of Barry Levinson v. Milko***, 124 Nev. 355, 362 (2008).

If the credibility assessment is not supported by substantial evidence, this Court may make the appropriate ruling. The opinions of Dr. Anderson and Dr. Betz ignore the "law of the case" that the discs were caused by the industrial accident. As discussed below, the "law of the case" results in a change of Dr. Betz's opinion and Dr. Anderson's opinion clearly is in conflict as his report states that the discs were not caused by the industrial accident. ***ROA 370.*** So in a nutshell, the Appeals Officer supported her decision on an opinion from a hired expert who never examined the Claimant, relied on medical evidence that the Appeals Officer already determined to be unreliable and was disregarded, and who was unable to determine whether the Claimant

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had any ratable impairment that pre-existed the industrial accident. It is respectfully submitted that a reasonable person cannot find the opinions of Dr. Betz credible given his reliance on facts which were already found by the Appeals Officer to be incorrect.

For these reasons, the Petitioner's Petition for Judicial Review should be granted due to the Appeals Officer's abuse of discretion and her error of law in how she applied NAC 616C.490.

2. RESPONDENTS POSITION REGARDING THE PRIOR AO DECISION IS BINDING AND THE APPEALS OFFICER MUST ACCEPT HER PRIOR FINDINGS AND CONCLUSIONS AS THE LAW OF THE CLAIM.

The Respndent argues that notwithstanding the prior AO Decision and its findings, the fact that Dr. Betz has his own opinion regarding the pre-existing condition and its relationship to the industrial injury as new, fair game.

It is well settled in Nevada that the purpose of the issue preclusion doctrine is to

> "to prevent multiple litigation causing vexation and expense to the parties and wasted judicial resources by precluding parties from relitigating issues." ***Univ. of Nev. v. Tarkanian***, 110 Nev. 581, 598, 879 P.2d 1180, 1191 (1994).

In ***Tarkanian***, the Nevada Supreme Court held that

> According to the Restatement's definition, a judgment is final if it is "sufficiently firm." Restatement (Second) of Judgments § 13 (Am. Law Inst. 1982). The Restatement's comments provide helpful guidance as to what "sufficiently firm" means. "A judgment may be final in a res judicata sense as to a part of an action although the litigation continues as to the rest." Id. at cmt. e. "The test of finality . . . is whether the conclusion in question is procedurally definite and not whether the court might have had doubts in reaching the decision." Id. at cmt. g. "Finality will be lacking if an issue of law or fact essential to the adjudication of the claim has been reserved for future determination . . . ," id. at cmt. b, or "if the decision was avowedly tentative," id. at cmt. g. Factors indicating finality include (a) "that the parties were fully

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heard," (b) "that the court supported its decision with a reasoned opinion," and (c) "that the decision was subject to appeal." Id.

Of the competing definitions proposed by the parties, the Restatement's definition best effectuates issue preclusion's purpose of increasing judicial efficiency by preventing parties from relitigating issues definitively decided by a court. See ***Tarkanian***, 110 Nev. at 598, 879 P.2d at 1191. The Restatement's definition achieves that purpose by according finality to any judgment a court intended to definitively resolve an issue fully litigated between parties. Under respondents' definition, by contrast, an interlocutory order could never be considered a final judgment as to an issue—even when the district court intended an interlocutory order to definitively resolve an issue.

Therefore, to the extent that this court did not formally adopt the Restatement's definition of "final judgment" ***in Tarkanian***, 110 Nev. at 599, 879 P.2d at 1191, we do so now. ***Id.***, at 5.

The Appeals Officer's prior decision, which was appealed by the Respondent but affirmed by the District Court, established the scope of the claim. The Respondent does not get to relitigate the issue as it was a final judgment. Further, the Appeals Officer is bound by that prior decision. The Appeals Officer previously found that Dr. Hall's opinions were inconsistent with the medical records. Given that she found that Dr. Hall's opinions were inconsistent with the medical records, it is reasonable to conclude that any subsequent opinion by a rating physician which relies on those incorrect opinions should also be bound to those findings. ***ROA 174.*** Dr. Hall confirmed that the only records he reviewed and was provided by the Respondent was a visit to the chiropractor dated January 13, 2016 and the MRI dated January 13, 2016. ***ROA 345.*** As stated in the Claimant's opening brief, there were over 19 doctors visits which were never given to Dr. Hall from the Respondent. ***ROA 300-339.*** The Respondent failed to provide Dr. Hall with these records

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which is one of the reasons which supported the Appeals Officer's Decision that Dr. Hall's opinions were inconsistent with the medical records. Dr. Hall also ignored the physical therapy and chiropractic records from treatment that he ordered. ***ROA 195-202.*** All this from a doctor that only saw the Claimant a total of five (5) times. ***ROA 189-192, 205-207, 215-216, 226-228 and 292-294.*** The Appeals Officer's decision that the apportionment is correct is not supported by substantial evidence because the basis for the apportionment excluded facts which have already been litigated, decided and is the law of the case.

The Findings of Facts and Conclusions of Law set forth in the Appeals Officer's Decision clearly document her failure to consider her prior findings and conclusions. Issue preclusion bars the Appeals Officer from disregarding the prior final judgment. She is bound by it. In the present matter, due to her disregarding her prior decision, her opinions are now based on faulty information. The end result is that her current decision is not based on substantial evidence.

3. AGAIN, THE APPEALS OFFICER DID NOT APPLY NAC 616C.490 AND NRS 616C.490.

The Respondent argues that the Appeals Officer correctly applied the laws to the facts of the case. First, did Dr. Anderson explain the basis for his apportionment? Dr. Anderson offered opinions and made conclusions of the pre-existing condition which disregarded the prior litigated facts and judicial adjudications of the effect of the pre-existing conditions on the subject claim. Dr. Anderson's report confirmed that he was never provided the AO Decision. ***ROA 365-371.*** Dr.

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Anderson's apportionment was incorrectly based on the position that the discs were pre-existing. ***ROA 369-371.*** Dr. Anderson specifically stated that "it was not logical to believe that these findings are related to the car accident that she was involved in 6 months earlier." ***ROA 370.*** This statement alone is sufficient justification to set the PPD of Dr. Anderson aside. Couple this with the list of factual mistakes contained in Dr. Anderson's report and the entire report of Dr. Anderson, notwithstanding Dr. Betz's review, renders the entire report fatally flawed.

The Claimant respectfully submits that a simple review of a comparison of Dr. Anderson's PPD findings versus the facts of the case clearly establishes that Dr. Anderson's conclusions were faulty.

Dr. Anderson's Findings	Facts which contradict Dr. Anderson's Findings.
1. The finding of the cervical spine spondylosis, stenosis and disc bulges cannot be logically attributable to this car accident/work injury. These findings provided indication for fusion surgery in the cervical spine.	It is already judicially determined that the two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level were directly related to the industrial accident. ***Exhibit 1, pages 167-168. ROA 1601-1602***
2. The claimant had responded well to physical therapy and medical treatment and had nearly completely resolved her cervical spine complaints prior to December 2015. She had no upper extremity symptoms at the time of release of care.	The Claimant made repeated complaints to her doctors regarding her cervical pain. ***Exhibit 1, pages 171-199. Specifically pages 175, 176, 177, 178, 179, 181, 184, 186, 189, 190 and 196. ROA 1605-1633.***
3. The work injury likely played some role in the onset of symptoms that led to surgery, but was not the primary cause.	The Claimant had no prior pre-industrial accident symptoms. The industrial injury was judicially determined to be the substantial contributing cause

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	of the resulting condition which required surgery. ***Exhibit 1, pages 167-168. ROA 1601-1602.*** There was no evidence that the Claimant would have ever needed surgery but for the industrial accident.
4. The Claimant had no documented cervical spine injury or pain immediately after the accident (symptoms began 6/30/2015). After at the cervical strain could be described as slight.	The Claimant complained of neck pain ion the day of the accident as documented in the C-4. ***Exhibit 1, page 36. ROA 1470.*** The C-1 also documents that the Claimant complained of neck pain. ***Exhibit 1, page 160. ROA 1594.*** On June 30, 2015, the Claimant presented to Dr. Hall at Specialty Health. The Claimant had complaints of neck discomfort that was described as moderate, diffuse, radiating into the right shoulder associated with stiffness. ***Exhibit 1, pages 37-40. ROA 1471-1474.*** On July 1, 2015, Dr. Brady assessed that the Claimant had spinal segment dysfunction at C6, C7. ***Exhibit 1, pages 41-44. ROA 1475-1478.*** On July 14, 2015, the Claimant continued to have ongoing lumbar and neck pain, that was moderate to severe, associated sleep disruption and stiffness, and had minimal improvement with chiropractic care. Dr. Hansen's assessment was that the Claimant had cervical disc displacement. ***Exhibit 1, pages 53-55. ROA 1487-1489.***

The law of this claim, which is not subject to re-litigation, is that the two large left paracentral disc protrusions at C6-6 and C-7 which are causing severe left NFS at each level were caused by the industrial accident. Dr. Anderson's opinions are flawed as are the opinions of Dr. Betz as they ignore the judicial

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determination that the primary cause of the resulting condition of the Claimant is the industrial injures. If you take that out of Dr. Anderson's PPD report, he does not explain the basis. Thus, his report is not consistent with the requirements of the ***AMA Guides, 5th Edition.***

Finally, Dr. Jempsa's PPD report was the rebuttal to Dr. Betz's testimony and report. Thus finding that Dr. Betz's opinion was uncontroverted is wrong. The Respondent provided the Betz report to Dr. Jempsa and Dr. Jempsa responded in an addendum. ***ROA 861-870.***

As stated above, the requisite determination of the rating physician is to determine the "scope and the nature of the impairment which existed before the industrial injury or the onset of disease." NAC 616C.490(7). According to the ***AMA Guides, 5th Edition***, the most recent impairment rating is calculated and then the prior impairment is calculated and deducted.[1]

The ***AMA Guides*** must be followed and a rating physicians report must not be left to speculation and guesses. There is no evidence that the Claimant had any ratable impairment at the time of her current industrial injury. Dr. Jempsa found this and Dr. Betz had to concede that fact during his testimony. Scientific

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[1] The *AMA Guides* provides the following example:

> "...in apportioning a spine impairment rating in an individual with a history of a spine condition, one should calculate the current spine impairment. Then calculate the impairment from any pre-existing spine problem. The preexisting impairment rating is then subtracted from the present impairment rating to account for the effects of the former. This approach requires accurate and comparable data for both impairments."

Another example is given on page 20 of the book entitled *Master the AMA Guides, Fifth*.

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methodology must be followed otherwise the rating physician opinion cannot meet the reasonable degree of medical certainty standard. This methodology requires an apportionment analysis as set forth in the ***AMA Guides***. Without such an analysis, apportionment is not warranted. Further, the clear and unambiguous language of NRS 616C.490(1) is mandatory. The rating physician **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. NRS 616C.490(1) Without the proper apportionment analysis required by both Nevada law and the ***AMA Guides***, prior medical records confirming that there was a rateable, prior residual impairment, and proof of a residual impairment at the time of the industrial injury [which would be rateable under the ***AMA Guides***], there can be no reasonable, substantiated apportionment.

After reviewing the numerous prior records which did not document any problems with the Claimant's cervical spine, Dr. Jempsa states apportionment is not appropriate. ***ROA 617***. NRS 616C.490 requires that there be evidence that a rateable impairment (as defined in the ***AMA Guides***) existed on the date of the industrial injury for apportionment to occur. NAC 616C.490 clarifies the nature and quantum of medical evidence necessary to sustain an apportionment. In this case there is no evidence that a rateable impairment existed on the date of the industrial injury. Nevada law is clear that if there is no documentation which exists to establish an impairment which existed on the date of the industrial injury, the impairment may not be apportioned.

NAC 616C.490(8).

The Appeals Officer committed error of law by not applying NAC 616C.490 and NRS 616C.490. It is undisputed that at the time of the industrial accident, the Petitioner had a 0% impairment due to any pre-existing condition that she may have had. Apportioning almost the entire award as pre-existing (75%) is a complete departure from Nevada law on apportionment of PPD ratings.

VI. CONCLUSION.

The Appeals Officer's Decision does not meet the requirements of NRS 233B.125. The Respondent essentially confirms that the Appeals Officer committed reversible errors of law by not applying NAC 616C.490 and NRS 616C.490 correctly by not even addressing Section 4 of NAC 616C.490. The Appeals Officer's Decision is also erroneous in view of the reliable, probative and substantial evidence on the whole record and results in an abuse of discretion as alleged by the Petitioner. The Appeals Officer's refusal to take into account her prior Decision renders a re-litigation of the scope of the claim which is another reversible error of law. The prior Hearing Officer got it right when he held that

> A review of Dr. Jempsa's PPD evaluation establishes that said evaluation was conducted in accordance with the ***AMA Guides***. As such, the Hearing Officer finds no medical evidence has been presented to justify the 75% apportionment and the Claimant is entitled to the 27% PPD award determined by Dr. Jempsa. ***ROA 601.***

WHEREFORE, the Petitioner respectfully asks that the Court grant the Petitioner's request for Judicial Review, reverse the Appeals Officer's Decision and reinstate the Hearing Officer's

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Decision, instructing the Respondent to offer the Petitioner the 27% PPD award.

Respectfully submitted this 22 day of May, 2020.

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By _____
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Attorney for Petitioner

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VII. CERTIFICATE OF COMPLIANCE

I, HERB SANTOS, JR., ESQ., 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 the applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e), which requires every assertion in the brief regarding matters in the record to be supported by appropriate references to the record on appeal. 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.

Respectfully submitted this 22 day of May, 2020.

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VIII. AFFIRMATION

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby certify that the preceding document, ***RESPONDENT'S REPLY BRIEF***, filed in case number CV19-01683, does not contain the social security number of any person.

Respectfully submitted this 22 day of May, 2020.

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IX. CERTIFICATE OF MAILING

Pursuant to N.R.C.P. 5(b), I hereby certify that I am over the age of eighteen years, and that on this date I electronically filed the foregoing document using the ECF system which will send notice of filing to

Lisa Whiltshire-Alstead, ESQ.

I also hereby certify that I deposited for mailing at Reno, Nevada a true and correct copy of the foregoing document addressed to:

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CCMSI Attn: Lisa Jones P.O. Box 20068 Reno, Nevada 89515-0068	Rajinder Nielsen, Esq., Appeals Officer Nevada Department of Administration 1050 E. William Street, Suite 450 Carson City, NV 89701
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DATED this 22 day of May, 2020.

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IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO, and the NEVADA DEPARTMENT OF ADMINISTRATION APPEALS OFFICER,

Respondents.

Case No: CV19-01683

Dept. No: 4

RESPONDENT'S ANSWERING BRIEF

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DISCLOSURE STATEMENT

Pursuant to NRS 233B.133(5), NRAP 28, and NRAP 26.1, the undersigned counsel of record certify that the following are persons and entities as described in NRAP 26.1(a), and must be disclosed.

With respect to the self-insured employer City of Reno ("Employer"), no disclosure is necessary as it is a governmental party.

These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Dated this 23rd day of April, 2020.

McDONALD CARANO LLP

By */s/ Lisa Wiltshire Alstead*
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ISSUE STATEMENT

The Appeals Officer Decision at issue here addresses the appeals of three separate Hearing Officer Decisions: AO1900471-RKN, AO1902049-RKN, and AO1802418-RKN. Petitioner Kimberly Kline's ("Claimant") Opening Brief, however, identifies that she solely petitions for judicial review of the issue on appeal in AO1900471-RKN, which was the Hearing Officer Decision dated July 19, 2018, reversing the Employer's third party administrator's May 24, 2018 and June 13, 2018 determination letters regarding apportionment of Claimant's permanent partial disability ("PPD") award. The May 24, 2018 determination letter notified Claimant that a PPD rating of twenty-seven percent (27%) was being held in abeyance. The June 13, 2018 determination letter offered Claimant a six percent (6%) PPD award based on an apportionment of seventy-five percent (75%) of the whole person impairment ("WPI") as non-industrial. On August 20, 2019, the Appeals Officer issued a decision reversing the July 19, 2018 Hearing Officer Decision and affirming the underlying determinations. The issue, then, is whether the Appeals Officer erred by finding that Claimant was properly offered a six percent (6%) PPD award based on apportionment of seventy-five percent (75%) of the Claimant's WPI as non-industrial and twenty-five percent (25%) industrial for her cervical spine.

STATEMENT OF THE CASE

This matter involves a workers' compensation claim filed by Claimant for an industrial injury that occurred on June 25, 2015, wherein she was injured while working for Employer as a parking enforcement officer. The Claimant received medical treatment for back and neck pain under her claim and was determined to be at maximum medical improvement ("MMI"), stable not ratable, and released to her full duty with no restrictions on October 28, 2015. On January 13, 2016, Claimant underwent an MRI, which found disc degeneration with large disc protrusions. On June 12, 2017, Claimant had a cervical spine decompression and fusion surgery. Claimant was determined to have reached MMI, was ratable and was released for full duty on September 11, 2017. A PPD evaluation was performed and Claimant was found to have a twenty-five percent (25%) WPI from the cervical spine, with seventy-five percent (75%) of the impairment apportioned

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as non-industrial. The self-insured Employer's third-party administrator ("TPA") issued a determination letter on December 5, 2017, offering a six percent (6%) PPD award. The Claimant appealed, a second PPD evaluation was conducted, and Claimant was found to have a twenty-seven percent (27%) WPI with none of the impairment apportioned as non-industrial. Due to the large discrepancy between the two PPD ratings, on May 24, 2018, the TPA determined to hold the PPD award in abeyance until the dispute was resolved.

After a records review, the TPA sent a determination on June 13, 2018, offering the claimant a PPD award of six percent (6%). Claimant appealed this determination. On July 19, 2018, after a hearing, a Hearing Officer Decision was entered reversing the TPA's determination. The Employer appealed and requested a stay. The stay was denied, and the TPA complied with the Hearing Officer's Order offering the Claimant a twenty-seven percent (27%) PPD award on September 20, 2018. Because the Employer maintains that apportionment is proper in this case, it offered the uncontested six percent (6%) as a lump sum or in installments, and, under NRS 616C.380, it will pay the remaining, contested twenty-one percent (21%) in monthly installments.

An Appeal hearing was conducted on May 1, 2019. An Appeals Officer Decision was filed on August 20, 2019, reversing the July 19, 2018 Hearing Officer Decision thereby affirming the TPA's determination apportioning the PPD award. The Claimant has now sought judicial review of this Appeals Officer Decision on the limited issue of whether apportionment was proper.

STATEMENT OF FACTS

I. BACKGROUND FACTS

A. Claimant's Industrial Injury and Initial Recovery

The Claimant worked as a parking enforcement officer for the City. On June 25, 2015, the Claimant was injured when her work vehicle was rear ended by another vehicle. (ROA 395). This was her second motor vehicle accident within a month, the first of which occurred on or around June 3, 2015. (ROA 409). Claimant's prior injury from the first accident was nearly resolved at the time of the second injury. (*Id.*)

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The Claimant was treated at St. Mary's Regional Medical Center for back and neck pain. (ROA 409-411). She was diagnosed by Dr. Richard Law with an acute lumbar radiculopathy, sprain of the lumbar spine, and acute pain the lower back. (ROA 410). On July 23, 2015, the claim was accepted for cervical strain. (ROA 453). The Claimant received medical treatment from Scott Hall, M.D. in addition to chiropractic care and physical therapy. (*See generally* ROA 388-352).

On October 28, 2015, Dr. Hall found the Claimant had reached MMI, was stable not ratable, and released her to full duty with no restrictions. (ROA 490). On November 6, 2015, the TPA sent the Claimant notice of intention to close the claim. (ROA 219). After an appeal, the Department of Administration concluded that the Claimant's industrial claim was closed prematurely. (ROA 167-175).

B. The Claimant was Diagnosed with Disc Degeneration and Underwent Spinal Surgery

On January 13, 2016, the Claimant saw Bryan Hansen, D.C., for chiropractic care (ROA 296-298). At the request of Dr. Hansen, Claimant then had a magnetic resonance imaging ("MRI") study completed the same day at Reno Diagnostic Centers ("RDC"). (ROA 299, 503). The MRI found disc degeneration with large disc protrusions at the C5-C6 levels resulting in complete effacement of CSF from the ventral and dorsal aspects of the cord with severe canal stenosis. (*Id.*). Dr. Hansen opined that the "MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision." (ROA 339).

On March 16, 2016, Dr. Hall noted that there was no evidence of neurologic involvement after the June 25, 2015 accident, specifically stating that the new onset of severe symptoms started quite suddenly and "it is uncertain if there is a relation to the industrial injury," also noting that the Claimant had sought orthopedic treatment before the June 2015 injury. (ROA 544-45). Dr. Hall concluded that "all indications were the [Claimant] had recovered completely from the industrial injury on June 25, 2015 by the end of [O]ctober 2015." (*Id.*)

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On July 5, 2016, the Claimant saw Lali Sekhon, M.D. who recommended a C4-C5 to C6-7 decompression and fusion surgery. (ROA 241-46). On June 12, 2017, Dr. Sekhon performed a C4-5, C5-6, and C6-7 anterior cervical decompression, interbody fusion. (ROA 1322-1327). On September 11, 2017, Dr. Sekhon determined that Claimant reached MMI, released her to full duty, and she was ratable. (ROA 748).

C. Claimant's PPD Evaluation Resulted in a 25% Whole Person Impairment with 75% Apportioned as Non-Industrial and She Was Offered a 6% PPD Award Based on This Evaluation

On November 10, 2017, Dr. Russell Anderson conducted a PPD evaluation. (ROA 558-564). Dr. Anderson concluded that the Claimant has a twenty-five percent (25%) WPI from the cervical spine. (ROA 564). Dr. Anderson's report also found the Claimant had underlying cervical spine issues that pre-dated her industrial injury, specifically addressing the January 2016 MRI[1] and radiography reports which show cervical spine degenerative discs with large protrusions at C5-6, C6-7, effacement of the CSF and severe canal stenosis. (ROA 559). Dr. Anderson stated, "It is not logical to believe that these findings are related to the car accident that she was involved in 6 months earlier." (ROA 563). Dr. Anderson thus apportioned seventy-five percent (75%) of the impairment as non-industrial. (ROA 563-64).

Dr. Anderson concluded that twenty-five percent (25%) of the Claimant's impairment was apportioned as industrial because: "[i] The Claimant had no documented cervical spine injury or pain immediately after the accident (symptoms began 6/30/2015). After that, the cervical strain could be described as slight; [ii] The findings of cervical spine spondylosis, stenosis, and disc bulges cannot be logically attributable to this car accident/ work injury. These findings provided the indication for fusion surgery in the cervical spine; [and iii] the Claimant had responded well to physical therapy and medical treatment and had nearly completely resolved her cervical spine complaints prior to December, 2015, and she had no upper extremity symptoms at the time of release from care." (ROA 563).

---

[1] Dr. Anderson's report lists the date of the MRI as "1/3/2016." (ROA 559). This appears to be a typographical error and refers to the Claimant's January 13, 2016 MRI ordered by Dr. Hansen.

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Dr. Anderson's report acknowledges that "the Claimant denies any prior upper extremity symptoms before this injury, however, this work injury likely played some role in the onset of symptoms that led to surgery, but was not the primary cause." (*Id.*) Dr. Anderson concluded that "apportioning this 75% of this claimant's impairment as non-industrial, we take 25% of this claimant's whole person impairment (which was 25% WPI), and we get 6% WPI related to this work injury (that occurred on 6/25/2015)." (ROA 564). On December 5, 2017, TPA issued a determination letter granting the Claimant a 6% PPD award based on Dr. Anderson's PPD evaluation. (ROA 568).

II. PROCEDURAL HISTORY

The Claimant appealed the TPA's December 17, 2018 determination to the Hearings Division of the Department of Administration, and on January 16, 2018, the Hearing Officer entered a Decision and Order remanding the determination finding a medical question regarding Dr. Anderson's 75% apportionment and ordering a second PPD evaluation. (ROA 1951-53). The Employer appealed this decision and requested a stay. (ROA 1940-47, 1949).

The Appeals Officer initially entered a stay, which was then lifted on March 27, 2018, and a second PPD evaluation was ordered. (ROA 1734-35, 1752-54). On May 8, 2018, James Jempsa, M.D., performed the second PPD evaluation. (ROA 1148-1187). Dr. Jempsa found a 27% whole person impairment and neglected to address apportionment. (*Id.*) Because apportionment was not considered, the TPA sent a follow up request asking Dr. Jempsa to review Dr. Anderson's PPD evaluation and address apportionment. (ROA 1162). On May 18, 2018, Dr. Jempsa provided an Addendum which stated, "You will need to contact Dr. Anderson concerning his rationale for apportionment. . . the Claimant stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. I have not received any medical records prior to the industrial injury. . . it is my opinion that apportionment is not necessary in this case." (ROA 1174).

On May 24, 2018, the TPA gave notice to the Claimant that it was holding the PPD award in abeyance pending a records review by Jay Betz, M.D. (ROA 1172). The Claimant appealed this determination to the Hearings Division of the Department of Administration. (ROA 1689).

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On June 4, 2018, Dr. Betz provided his review. (ROA 1189). Dr. Betz noted that both Dr. Anderson and Dr. Jempsa agree there is a twelve percent (12%) WPI utilizing Table 15-7 of the of the Fifth Edition of the American Medical Association Guides to the Evaluation of Permanent Impairment ("AMA Guides"), and that there is a one percent (1%) whole person impairment for sensory deficit in the left C6 distribution. (ROA 1192). "However, there was a large discrepancy between the active range of motion findings." (*Id.*). Dr. Betz observed that Dr. Jempsa provided no discussion or explanation for the significant variation and noted that "[i]t is well recognized that patients learn from prior rating experience. This can have a great effect when findings are 'under the influence of the individual' such as active range of motion which requires the full effort and cooperation of the patient to be valid." (ROA 1192-94). Dr. Betz states that, "absent an objective basis for the variation, Dr. Anderson's range of motion findings should have priority." (ROA 1193).

Dr. Betz's report carefully sets forth the medical evidence supporting his conclusion that Claimant had a pre-existing condition:

> Dr. Anderson correctly points out that the patient's cervical pathologies were primarily degenerative in nature and pre-existing. This conclusion is further supported by Dr. Hall's opinion on March 16, 2016, in which he noted Ms. Kline's cervical symptoms were initially consistent with a sprain strain and that she recovered completely from the industrial injury with conservative treatments by the end of October 2015. He goes on to conclude that there is no objective evidence to connect the patient's significant MRI findings of January 13, 2016 with the industrial injury. It is also informative that Ms. Kline had no symptoms or examination findings of neck injury at time of her initial presentation to the ER and was not found to have acute injury related pathologies on MRI.
>
> If the occupational incident had significantly aggravated the patient's pre-existing pathologies, the development of radiculopathy symptoms and findings would be expected in the first few days or weeks and not 5 months later. Consequently, it is likely that the patient's radicular symptoms were the result of a natural progression of her significant multilevel degenerative changes rather than the [industrial] injury.

(ROA 1193).

Dr. Betz's records review also confirms that Claimant had a non-industrial car accident several months prior to the industrial accident, resulting in low back pain. (ROA 1189). An MRI

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taken one month prior to the industrial injury confirmed that Claimant's herniated disc at L3-4 and L4-5 had nearly resolved in the interim. (ROA at 1190). Claimant's symptoms reported after the June 25, 2015 industrial accident included neck, upper back and low back pain. (ROA 1190). Dr. Betz found that the Claimant's January 13, 2016 cervical spine MRI was remarkable for disc degeneration with large disc protrusions at C5-6 and C6-7. (*Id.*) Dr. Betz observed that Claimant's neurosurgical consultation with Dr. Sekhon indicated the Claimant "had pre-existing spondylosis C4 through C7 with cord compression C5-6 and C6-7, mobile spondylolisthesis at C4-5 and failed conservative therapy." (ROA 1191). Dr. Sekhon also suggested that the industrial accident exacerbated her underlying stenosis. (*Id.*) Dr. Betz reviewed x-rays taken on April 21, 2017 showing "mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7." (*Id.*) An "MRI on the same day showed moderate posterior disc osteophyte complex through C4 through C6 resulting in mass effect upon the ventral spine cord and moderate to severe central canal stenosis." (*Id.*)

Dr. Betz concluded his records review agreeing with Dr. Anderson's findings on apportionment and noting Dr. Anderson's conclusions "are well supported by the medical record, known pathologies, AMA guides and Nevada Administrative Code." (ROA 1193). Based on Dr. Betz's assessment, on June 13, 2018, the TPA issued a determination offering the Claimant a six percent (6%) PPD award consistent with Dr. Betz and Dr. Anderson's findings. (ROA 618). The Claimant also appealed this determination.

A hearing was conducted before a Hearings Officer on July 12, 2018 addressing both the third-party administrator's May 24, 2018 and June 13, 2018 determinations. (ROA 601-603). The Hearing Officer issued a Decision and Order reversing the determinations and finding "that no evidence has been presented to justify 75% apportionment and the Claimant is entitled to the 27% PPD award determined by Dr. Jempsa." (ROA 601). The Employer appealed this decision. (ROA 1-22).

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An appeal hearing was held on May 1, 2019. Claimant provided witness testimony at the appeal hearing and Dr. Betz was found to be qualified and admitted as an expert and provided expert testimony. (ROA 23-159). Claimant offered no expert witness to rebut Dr. Betz's testimony.[2] (*Id.*) Dr. Betz testified that Claimant's cervical pathologies were primarily degenerative in nature and pre-existing, including the Claimant's spondylitis and stenosis. (ROA 51-58, 109, 111). He explained:

> So, impairment simply means [a] derangement. It's a derangement of normal anatomy or physiology. ***And this patient did have a previous derangement of normal anatomy***. So by definition, she had a pre-existing impairment. ***It may not have been symptomatic***; I acknowledge that. ***It may not have required surgery at that time***; I acknowledge that. ***But there's no question, based on the subsequent imaging, subsequent opinion, that the patient had prior derangement***, prior-a prior condition that has now contributed mightily to her present impairment, because it resulted in a fusion.

(ROA 108-109) (emphasis added). Dr. Betz noted that the workers' compensation apportionment regulation does not require that a prior impairment be ratable, just that there is a pre-existing condition that is contributing significantly to the current impairment. (ROA 68, 109-110).

Dr. Betz also explained that Claimant's MRI revealed moderate posterior disc osteophyte complex (disc protrusions) through the C4 through C6 vertebrae, and he testified that osteophytes take years, if not decades, to develop (ROA 51-52, 58-59). Dr. Betz also testified that neither the first car accident several months before the industrial injury, nor the second car accident causing the industrial injury were likely to have caused Claimant's disc protrusions. (ROA 84). Dr. Betz explained that if the car accident was the cause of Claimant's resulting conditions, as opposed to an aggravation of a pre-existing condition, the symptoms would have been immediate instead of having a gradual onset. (ROA 53-54, 55-56). Dr. Betz also testified as to each historical record, diagnosis, x-ray, and MRI that he relied upon to determine apportionment. (ROA 62-69).

On August 20, 2019, the Appeals Officer issued a Decision finding "Dr. Betz to be a credible witness and his testimony is given great weight. Dr. Betz's testimony was uncontroverted

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[2] Dr. Betz was also made available for deposition, but Counsel for Claimant declined to depose him. (ROA 102:9-10).

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at hearing and no opposing or contradicting expert witness testimony was provided." (ROA 7:19-21). The Appeals Officer also concluded that Dr. Jempsa was not credible and his report was not given any weight because he failed to consider Claimant's pre-existing condition as evidenced in the medical reporting. (ROA 14-18). The Appeals Officer reversed the Hearing Officer Decision dated July 18, 2018, and found that "Employer's third-party administrator properly offered Claimant a 6% PPD award following apportionment of the 25% PPD award as 75% non-industrial and 25% industrial, based on Dr. Anderson's PPD evaluation and Dr. Betz's records review report." (ROA 19). On August 28, 2019, Claimant filed a petition for judicial review seeking review by this Court of the Appeals Officer Decision on the issue of apportionment.

ARGUMENT SUMMARY

At the outset, Claimant mischaracterizes the standard of review on appeal as *de novo*, arguing the appealed issue is solely a question of law as to whether the Appeals Officer correctly interpreted NRS 616C.490(9) and NAC 616C.490 with respect to apportionment. Yet, the determination of whether the Hearing Officer erred by reversing the TPA's determinations holding the twenty-seven percent (27%) PPD award in abeyance and offering a six percent (6%) award, based on apportionment of Claimant's impairment, required the Appeals Officer to apply the facts to the law. These factual findings and fact-based conclusions of law cannot be disturbed on appeal and must be given ***deference***. The Claimant requests that this Court substitute its opinion for that of the Appeals Officer as to the application of the evidence to the law. This is ***impermissible*** when a mixed question of law and fact is at issue. *See* NRS 233B.135(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 substantial evidence, including Dr. Betz's report and credible testimony at the May 1, 2019 Appeals Officer hearing, and the medical evidence in the record, unequivocally establishes that apportionment of Claimant's PPD award was proper pursuant to NAC 616C.490. This evidence is ***uncontroverted*** and Claimant has provided ***no*** contrary medical evidence or expert opinion. The medical evidence establishes that Claimant had a pre-existing degenerative spinal condition that contributed significantly to her current impairment. While the industrial car accident

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may have aggravated her pre-existing condition, it was not the primary cause; and the PPD award properly reflects this. The medical evidence and expert testimony fully support the Appeals Officer's application of the facts to the law, finding and concluding that Claimant was properly awarded a six percent (6%) PPD award, which apportioned the twenty-five percent (25%) WPI of the cervical spine as seventy-five percent (75%) non-industrial and twenty-five percent (25%) industrial.

Further, the Appeals Officer correctly interpreted NRS 616C.490 and NAC 616C.490 in finding that apportionment does not require that the pre-existing condition be a ***ratable*** impairment, or that the medical records evincing the pre-existing condition pre-date the industrial injury. Rather, a rating physician must look for a prior impairment. This can be shown in medical records post-dating the industrial injury, such as Claimant's MRI here revealing a degenerative condition that existed before the industrial injury. So, Claimant incorrectly insists that apportionment for a pre-existing disease or condition requires a "ratable" impairment to have existed on the date of the industrial injury. This is contrary to the plain language of NAC 616C.490 which simply requires an "impairment" with ***no requirement*** that the pre-existing condition or disease be previously rated. Similarly, her contention that apportionment is improper due to a lack of prior documentation of the pre-existing condition is unpersuasive where Dr. Betz has expressly identified the x-rays, historical records and diagnoses confirming Claimant's prior impairment as required by NAC 616C.490(5).

Finally, the Claimant's reliance on "the law of the case" is misplaced. Although she argues that the Appeals Officer Decision relitigates facts decided in a previous appeal, Claimant ignores the fact that the question on appeal in the earlier decision was whether claim closure without a PPD rating was proper.[3] While the January 18, 2017 Appeals Officer Decision gave more weight to Dr. Sekhon's and Dr. Hansen's medical opinions, and less weight to Dr. Hall's opinion that Claimant did not suffer a ratable impairment, the earlier decision makes no findings as to the propriety of apportionment. That decision also pre-dated Dr. Anderson's PPD evaluation, as well Dr. Betz's report and expert testimony, upon which the Appeals Officer specifically relied in reaching the

[3] Decision, Appeal No. 56832-RKN (filed January 18, 2017) (ROA 166-176).

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decision at issue here. The prior decision concluded that the industrial injury aggravated a pre-existing condition under NRS 616C.175(1). This is not inconsistent with the present decision, which found that the medical evidence establishes that Claimant had a pre-existing cervical spine condition which mandates apportionment under NAC 616C.490. With the decision supported by the substantial evidence and the law, there is no basis to grant review and the Petition for Judicial Review should be denied.

ARGUMENT

I. STANDARD OF REVIEW

A court may set aside a final decision of an agency if the decision is arbitrary, capricious, in violation of statute, characterized by an abuse of discretion or affected by error of law. NRS 233B.135(3); *Ranieri v. Catholic Community Services*, 111 Nev. 1057, 1061, 901 P.2d 158, 161 (1995). While Claimant urges this Court to apply a *de novo* standard based on statutory interpretation, that is not the applicable standard here. *See i.e., Elizondo v. Hood Machine, Inc.*, 127 Nev. 780, 783, 312 P.3d 479, 482 (2013) (a de novo standard of review applies to questions of law); *cf. Elliot v. Resnick,* 114 Nev. 25, 32, n.1, 952 P.2d 961, 966, n.1 (1998) ("an administrative agency charged with the duty of administering an act is impliedly clothed with the power to construe the relevant laws and set necessary precedent to administrative action, and the construction placed on a statute by the agency charged with the duty of administering it is entitled to deference"); *Am First Fed. Credit Union v. Soro*, 131 Nev. 737, 740, 359 P.3d 105, 106 (2015) (contract interpretation "is a question of law, and, as long as no facts are in dispute, the court review contract issue de novo").

Rather, in reviewing a ***mixed question of law and fact,*** an appellate court gives deference to the lower court's findings of fact but independently reviews whether those facts satisfy the applicable legal standard. *See Hernandez v. State*, 124 Nev. 639, 647, 188 P.3d 1126, 1132 (2008) (abrogated on other grounds by *State v. Eighth Jud. Dist. Ct.*, 134 Nev. 104, 412 P.3d 18 (2018)). An "agency's fact-based conclusions of law 'are entitled to deference, and will not be disturbed if they are supported by substantial evidence.'" *Law Offices of Barry Levinson, P.C. v. Milko,* 124

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Nev. 355, 362, 184 P.3d 78, 383-84 (2008) (internal citation omitted). "Substantial evidence exists if a reasonable person could find the evidence adequate to support the agency's conclusion, and [the court] may not reweigh the evidence or revisit an appeals officer's credibility determination." *Id.* at 362, 184 P.3d at 384. While a "district court is free to decide purely legal questions without deference to an agency determination, ***the agency's conclusions of law, which will necessarily be 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) (internal citation omitted) (emphasis added).

Here, Claimant's Opening Brief ***ignores this standard.*** Yet, the Claimant takes issue with the Appeals Officer's findings of facts and conclusions of law which are based solely on the substantial evidence. The Appeals Officer's findings and conclusions must be given deference and cannot be disturbed, as suggested by Claimant, where they are supported by the substantial evidence. As such, the Petition for Judicial Review should be denied.

II. THE SUBSTANTIAL EVIDENCE UNEQUIVOCALLY ESTABLISHES THAT APPORTIONMENT OF CLAIMANT'S PPD AWARD WAS PROPER AND THE APPEALS OFFICER'S CREDIBILITY DETERMINATIONS ARE ENTITLED TO DEFERENCE.

Under Nevada law, a PPD award must be apportioned based on what percentage of the impairment is due to a pre-existing disability:

> 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.

NRS 616C.490(9) [effective through December 31, 2019]. The Nevada Administrative Code sets forth the following regulations governing apportionment:

> 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 pre-existing 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 pre-existing 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***

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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.

NAC 616C.490 (emphasis added).

Here, the medical evidence establishes that Claimant's present impairment is due in part to a pre-existing condition. As such, NAC 616C.490(1)-(2) required her PPD award to be reduced by the portion reasonably attributable to the pre-existing condition. The Appeals Officer found that the medical documentation and expert testimony here establish that the attribution of seventy-five percent (75%) of Claimant's impairment to the pre-existing condition is reasonable. (ROA 17-18). This fact-based conclusion is entitled to deference.

In her Opening Brief, Claimant enumerates what she claims are nine "conclusive facts" conceded by Dr. Betz during his expert testimony at the July 12, 2018 Appeals Hearing. (*See* Opening Brief at 8-9). These "facts" are inaccurate statements because they are taken out of context and fail to consider whole of the testimony relied on by the Appeals Officer in the Decision. Taken as a whole, Dr. Betz's testimony fully supports the Appeals Officer Decision.

Each "fact" is reproduced here, along with the contextual testimony conspicuously absent from Claimant's brief:

> 1. Dr. Betz was unable to apportion what pain was related to degenerative changes versus what was caused by the C5/6 and C6/7 herniations which were causing cord compression.

(*Id.* at 9) (citing ROA 83). Dr. Betz's full answer to Claimant's counsel's question was:

> Well, the evidence is she had herniations. She had some degenerative protrusions, As we all know, neck and spine pain is multi-factorial, it's impossible to assign, with any specificity, how much of it is disc related, how much of it is facet related, how much of it is ligament related, . . .

(ROA 83). The issue here is not how much pain is due to degenerative changes and how much is due to herniations causing cord compression, but rather how much of the present impairment is reasonably attributable to the pre-existing condition. In the Decision, the Appeals Officer

concludes that "[h]ere, the medical evidence establishes that the Claimant had a pre-existing condition which mandates the rating physician to apportion under NAC 616C.490(1)." (ROA at 11). The Decision cites medical reporting by Dr. Anderson and Dr. Betz, supported by Dr. Hall's March 16, 2016 opinion, and the January 13, 2016 MRI showing degenerative changes, as the basis for this conclusion. (*Id.*) The Appeals Officer also found based on the evidence that "Dr. Anderson's apportionment of the Claimant's present impairment as 75% non-industrial and 25% industrial was proper and credible." (ROA 17).

Claimant further contends:

> 2. Dr. Betz conceded that if the C5/6 and C6/7 protrusions were caused by the industrial accident, it would change his opinion on apportionment.

(Opening Br. at 9) (citing ROA 86). This is misleading. Despite Claimant's counsel's repeated attempts at the hearing to get Dr. Betz to admit that the C5/6 and C6/7 protrusions were caused by the industrial accident, Dr. Betz ***never*** says this. Instead, when responding to Claimant's counsel's hypothetical assumption that this was the case, Dr. Betz responded that he would alter his opinion on apportionment:

> [i]f I had evidence that the patient had immediate pain and found to have disc herniations in the weeks or months immediately following the accident, consistent with the accident, consistent with the symptoms then, absolutely, ***it's not the case here***, but absolutely.

(ROA 86). In fact, the Appeals Officer found it significant that there was ***no evidence*** that Claimant had symptoms or examination findings of neck injury at time of her initial presentation to the ER and was not found to have acute injury related pathologies on MRI. (ROA 11).

Claimant relies heavily on the fact that there is no evidence of a ***ratable impairment*** to her cervical spine prior to the industrial accident, and that there is no documentation of an impairment that predates the industrial accident:

> 3. Dr. Betz conceded that there was no evidence of a ratable impairment to the cervical spine prior to the industrial accident. (Opening Br. at 9) (citing ROA 87).
>
> 4. Dr. Betz confirmed that there were no prior records that supported an impairment to the cervical spine prior to the industrial accident. (Opening Br. at 9) (citing ROA 88).

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> 5. Dr. Betz confirmed that there were no prior medical opinions that supported an impairment to the cervical spine prior to the industrial injury under the AMA Guides, 5th Edition. (*Id.*)
>
> 6. Dr. Betz confirmed that there is not one medical record that documents that the Petitioner had prior pre-industrial accident symptoms for her cervical spine. (Opening Br. at 9) (citing ROA 94).

However, as explained by Appeals Officer in applying the law to these facts, the AMA Guides neither require that medical records evincing a pre-existing impairment predate the industrial injury nor that the pre-existing impairment was ratable. (ROA 14). Similarly, NAC 616C.490 does not require rating of a pre-existing impairment, or that the records predate the industrial injury. (*Id.*) NAC 616C.490(6) provides:

> If there are pre-existing 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.

NAC 616C.490(6). The Nevada Supreme Court has held that "the clause 'which existed before the industrial injury or the onset of the disease' ***refers to the impairment and not the documentation***." *Ransier v. SIIS*, 104 Nev. 742, 744, 766 P. 2d 274, 275 n.1 (1988) (emphasis added). The Appeals Officer Decision is supported by Dr. Anderson's and Dr. Betz's reports, and Dr. Betz's expert testimony, all of which point to medical evidence of pre-existing stenosis, spondylitis, and osteophytes ***which take years if not decades to form***. (ROA 17-18).

Claimant also contends:

> 7. Dr. Betz confirmed that there is not one medical record that the Petitioner would have ever needed to have a cervical fusion prior to the industrial accident. (Opening Br. at 9) (citing ROA 95).

This selective citation, however, ignores Dr. Betz's other testimony that "I think it's highly likely that she would've ended up with a surgical fusion with or without the industrial accident" (ROA 95) and that:

> Fusions are only done because there are degenerative changes associated with it or evidence of instability, typically again related to degeneration. ***So, fusion would be***

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> ***typically be the recommended procedure for an acute herniation causing neurologic impingement.***"

(ROA 87) (emphasis added). Dr. Betz is clear that the industrial accident was not the primary cause of Claimant's cervical spine condition:

> So, this patient clearly, clearly has a pre-existing condition. Okay? So, and ***we know that the fusion was done to address that pre-existing condition***. It may have been aggravated by the occupational incident. ***I think that's arguable but may have been***. I acknowledge it's a possibility. But clearly, ***the primary, if not 75% to 90% reason this fusion was performed was to address progressive symptoms related to multilevel degenerative disc disease***. . .

(ROA 67) (emphasis added). When the whole of Dr. Betz's testimony is considered, it plainly supports the Appeals Officer's finding that Claimant had a pre-existing condition and apportionment of her PPD award was therefore proper.

Next, Claimant emphasizes the fact that:

> 8. Dr. Betz conceded that under the AMA Guides, 5th Edition, the rating doctor has to assess whether a condition was ever symptomatic and whether there was an aggravation and both he and Dr. Anderson found no evidence that any cervical pre-existing condition was ever symptomatic prior to the industrial accident. (Opening Br. at 9-10) (citing ROA 98).

However, as discussed above, the absence of symptoms prior to the industrial accident does not preclude apportionment under NAC 616C.490.

Finally, Claimant again misstates Dr. Betz's testimony citing the fact that:

> 9. Dr. Betz conceded that the PPD completed by Dr. Jempsa (27%) is correct on apportionment if the disc protrusions were caused by the industrial accident. (Opening Br. at 10) (citing ROA 106).

As Dr. Betz states repeatedly over the course of his testimony, his opinion based on the medical evidence is that the disc protrusions were ***not*** caused by the industrial accident. Indeed, the full exchange between Claimant's counsel and Dr. Betz was actually:

> HERB SANTOS: Would it be fair to say that Dr. Jempsa's [sic] opinion would be correct on apportionment if the disc protrusions were caused by the motor vehicle?
>
> DR. JOHN BETZ: [laughs] ***Well, if red is determined is blue, then I guess so, but–***

HERB SANTOS: That's all I have, thank you Doctor.

APPEALS OFFICER: Let him finish his answer.

DR. JOHN BETZ: Okay.

APPEALS OFFICER: Finish your answer, Dr. Betz, please.

DR. JOHN BETZ: I think that question [inaudible] ridiculous but if there – if it was proven somehow that all the patient's cervical pathologies, all the spurring, the osteophytes, the bulging, the spondylolisthesis, the spondylosis, they're all related to that incident, ***which is preposterous***, then yes, he's correct.

(ROA 106) (emphasis added). Claimant is incorrect that the Appeals Officer's prior decision found that her disc protrusions were caused by the industrial injury. Rather, the prior decision, which considered whether claim closure was proper, observed that "Dr. Hansen felt there was a high probability within a medical degree of certainty that the Claimant's injuries were ***related to*** the rear-end collision she had recently sustained." (ROA 170). Based in part on Dr. Hansen's opinion, the Appeals Officer found that "[t]he substantial evidence supports a finding that the industrial accident aggravated the pre-existing condition and that the resulting condition was the substantial contributing cause of the resulting condition" and that Claimant had "met her burden of proof with substantial evidence that she is not at maximum medical improvement and needs further treatment." (ROA 174). This decision predated the spinal fusion surgery and the PPD evaluations by Dr. Anderson and Dr. Jempsa, as well as the records review by Dr. Betz. The prior decision does not preclude the Appeals Officer from taking that subsequent medical history and documentation into consideration when reaching the Decision at issue here.

Finally, the Appeals Officer Decision sets forth the factual basis for each credibility determination. The Decision concludes that Dr. Anderson's and Dr. Betz's medical opinions and expert testimony were found credible and satisfy the requirements for apportionment under NAC 616C.490. (ROA 16). Specifically, the Appeals Officer found that both physicians explained the underlying basis for apportionment by citing pertinent data and medical records that supported their analyses. (*Id.*) The Appeals Officer further noted that Dr. Betz provided detailed expert testimony as to each record relied upon and how that contributed to his apportionment analysis, as

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well as provided extensive testimony verifying that "there was documentation of the prior factor, and that there is evidence indicating the prior factor causes or contributed to the present impairment based on a reasonable probability," as required by the AMA Guides. (*Id.*) The Appeals Officer also sets forth the basis for giving no weight to Dr. Jempsa's PPD evaluation. First, Dr. Jempsa's range of motion findings were questionable because "[i]t is well recognized that patients learn from prior rating experience." Dr. Jempsa's failed to apportion because the Claimant stated that she had no problems with her neck prior to the industrial injury, and because he had received no records prior to the industrial injury on June 25, 2015. (ROA 18). The Appeals Officer concluded that this was also questionable because the medical evidence demonstrates pre-existing stenosis, spondylitis, and osteophytes, which form over the course of years, if not decades. (ROA 18). And, as discussed *supra*, NAC 616C.490 does not require that the evidence of a pre-existing condition predate the industrial injury. The Appeals Officer's credibility determinations, which are supported by substantial evidence, ***may not be disturbed on appeal*** as requested by Claimant. *See Law Offices of Barry Levinson, P.C.* 124 Nev. at 362, 184 P.3d at 384.

III. CLAIMANT'S RELIANCE ON THE LAW OF THE CASE IS MISPLACED.

Claimant argues that the Appeals Officer previously found Dr. Hansen's opinion that Claimant's disc protrusions at C5-6 and C6-7 appeared to be directly related to the recent industrial motor vehicle collision to be credible. (*See* Opening Brief at 14) (citing ROA 170). By the same token, Claimant contends the Appeals Officer's earlier decision gave Dr. Hall's contradictory opinion less weight because it was inconsistent with the medical record. (*Id.* at 15-16). Somewhat perplexingly, Claimant then argues that this finding as to Dr. Hall's opinion is binding on any subsequent decision by a rating physician. (*See* Opening Br. at 14-17). Claimant cites no legal authority for this argument and, indeed, none can be found.

What Claimant ignores is that the January 18, 2017 Appeals Officer Decision addressed the issue of whether claim closure was proper without a PPD evaluation. (ROA 166). The medical records showed that Claimant was released by Dr. Hall notwithstanding her complaints of neck pain, and that Dr. Hall never ordered any diagnostic tests to determine the extent of her industrial

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injury. (ROA 173). The Appeals Officer therefore found Dr. Hall's opinion that Claimant had reached MMI, was stable and not ratable, and his decision to release her to full duty with no restrictions, to be unsupported by the objective medical evidence. (ROA 173). This was the basis for the Appeals Officer's order rescinding claim closure, as Claimant's industrial injuries were not MMI, and requiring the Insurer to provide all appropriate benefits to Claimant, including the surgery with Dr. Sekhon. (ROA 173-174). The January 18, 2017 Appeals Officer Decision plainly contemplated a possible future PPD evaluation, once Claimant had completed treatment and was determined stable. (ROA 174).

Dr. Hall also opined that it was likely Claimant had disc degeneration prior to the industrial injury which may have been exacerbated by the industrial injury, and that there was no objective evidence connecting the MRI findings to the industrial injury. (ROA 171). At no point in the January 17, 2018 Appeals Officer Decision does the Appeals Officer state that the decision to give Dr. Hall's opinion no weight is somehow binding on future rating physicians. Rather, the Appeals Officer stated that "I found Dr. Hall's opinions to be inconsistent with the medical evidence and he ***failed to state his opinion(s) within a reasonable degree of medical probability***. Therefore, I give his opinions no weight." (ROA 174). Importantly, the earlier Appeals Officer Decision also concluded that "[t]he substantial evidence supports a finding that the industrial accident aggravated the preexi[s]ting condition . . ." (ROA 174). The current decision upholding apportionment based on a pre-existing condition is therefore completely consistent with the law of the case.

Here, as discussed in Section II *supra*, the Appeals Officer based the decision upholding apportionment primarily on the medical evidence from Dr. Anderson and Dr. Betz. Dr. Betz was expressly found "to be a credible witness and his testimony is given great weight." (ROA at 7). The Appeals Officer also states that:

> Based on the medical reporting of Dr. Betz and Dr. Anderson, along with the expert testimony of Dr. Betz, the Appeals Officer concludes that the medical evidence establish Claimant had a pre-existing condition. ***Dr. Betz and Dr. Anderson are found to be credible and their opinions given the most weight.***

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(ROA 13-14). While it is true that Dr. Betz's report notes that Dr. Hall's opinion supports Dr. Anderson's conclusion that the Claimant's cervical spine pathologies were primarily degenerative in nature and pre-existing, the Appeals Officer Decision does not rely on Dr. Hall's opinion alone. (ROA 11). In his expert testimony Dr. Betz explained that Dr. Hall "was probably correct that the [Claimant] suffered a sprain/strain," and that she did eventually improve "as would be expected with a . . . sprain/strain." (ROA 55). However, Dr. Betz testified that there was not "any significant relationship" between those symptoms and the degenerative disc disease findings on the Claimant's MRI results. (ROA 55-56). Dr. Betz testified that the reason it took Claimant seven months to improve from the sprain/strain was because "there was unrecognized underlying multilevel degenerative disc changes." (ROA 55). Moreover, regardless of whether Dr. Betz relied on Dr. Hall's opinion, what is at issue here is Claimant's pain and additional treatment related to the pre-existing degenerative condition which began ***after*** she had recovered from the industrial sprain/strain and was released by Dr. Hall. Thus, Dr. Betz's opinion incorporating Dr. Hall's opinion and his reliance on Dr. Hall's reporting was not inconsistent with the Appeals Officer's prior decision.

Dr. Betz's record review report and extensive expert testimony make clear that he considered ***all*** medical reporting and imaging studies in reaching his conclusion that the medical evidence establishes that Claimant had a pre-existing condition. (ROA 11-13). Contrary to Claimant's bald assertion that the Appeals Officer Decision does not meet the requirements of NRS 233B.125,[4] the findings of fact and conclusions of law in the decision are supported by a

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[4] NRS 233B.125 provides:

> A decision or order adverse to a party in a contested case must be in writing or stated in the record. Except as provided in subsection 5 of NRS 233B.121, **a final decision must include findings of fact and conclusions of law, separately stated.** ***Findings of fact and decisions must be based upon a preponderance of the evidence.*** **Findings of fact, if set forth in statutory language, must be accompanied by a concise and explicit statement of the *underlying facts supporting the findings*.** If, in accordance with agency regulations, a party submitted proposed findings of fact before the commencement of the hearing, the decision must include a ruling upon each proposed finding. Parties must be notified either personally or by certified mail

preponderance of evidence, and the Appeals Officer enumerated each of the facts underlying those findings. This is not a re-litigation of the facts, as Claimant would have it.[5] Rather, in view of ***all*** the medical evidence, much of which did not exist at the time of the prior Appeals Officer Decision relied on by Claimant, the Appeals Officer properly concluded that Claimant had a pre-existing condition mandating apportionment of her impairment under NAC 616C.490. This presents a new question of law not previously addressed by an Appeals Officer and which requires a separate and distinct legal analysis and application of the medical evidence than that performed in the prior decision.

IV. THE APPEALS OFFICER CORRECTLY INTERPRETED NEVADA LAW GOVERNING APPORTIONMENT AND DID NOT ABUSE HERDISCRETION

Claimant argues that because she had no ratable impairment or symptoms due to her pre-existing cervical spinal condition prior to the industrial injury, there must be no apportionment of the PPD award. This is not the law. NRS 616C.490(9) states:

> 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.

NRS 616C.490(9) [effective through December 31, 2019]. The Nevada Administrative Code provides the procedure for completing apportionment. *See* NAC 616C.490. The Administrative Code requires a precise apportionment to be completed "if a prior evaluation of the percentage of impairment is available and recorded for the pre-existing impairment." NAC 616C.490(3).

> of any decision or order. Upon request a copy of the decision or order must be delivered or mailed forthwith to each party and to the party's attorney of record.

(emphasis added).

[5] Ironically, while Claimant attempts to characterize a review of the prior medical as an impermissible re-litigation of facts previously determined as to the credibility of Dr. Hall, in reality, Claimant is ***impermissibly*** asking this Court to make its own findings of credibility regarding Dr. Betz and to ***substitute*** those in place of the Appeals Officer's credibility determinations regarding Dr. Betz. The Appeals Officer's credibility determinations and reliance of Dr. Betz's expert testimony and report must be given deference and cannot be disturbed.

However, the Administrative Code specifically contemplates the situation here, where there is no prior rating evaluation of the pre-existing condition. In such a case, the Administrative Code provides that:

> 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.***

NAC 616C.490(4)-(5) (emphasis added). "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." NAC 616C.490(7).

The Appeals Officer expressly found that both Dr. Anderson and Dr. Betz identified the pertinent documentation, including x-rays, MRIs, historical records and diagnoses which established a prior impairment. (ROA 15). The Decision stated that this documentation supported the scope and nature of the pre-existing impairments. (*Id.*) Dr. Betz also testified as to the nature and scope of the pre-existing impairment, stating that "the nature of the [pre-existing] condition is multilevel-significant spondylolisthesis or degenerative disc disease. The nature was, I would say moderate to severe." (ROA 63). Specifically, the Appeals Officer noted that Claimant initially treated for neck issues that then resolved. (*Id.*) Months later, she exhibited new symptoms indicating a nerve root deficit. (*Id.*) Based on the records from Dr. Sekhon, who performed Claimant's spinal fusion surgery, in addition to MRI and x-ray records, demonstrating the scope

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and nature of the impairment, Dr. Betz testified that the present impairment was at least fifty percent (50%) due to Claimant's pre-existing impairment. (ROA 16). The Appeals Officer thus concluded that Dr. Betz and Dr. Anderson established the underlying basis for apportionment as required by NAC 616C.490(5)-(7).

The AMA Guides also provide a framework for apportionment, requiring that (1) there is documentation of the prior factor; (2) the current impairment is greater as a result of the prior factor; and (3) there is evidence indicating the prior factor caused or contributed to the impairment based upon a reasonable probability. (*See* Opening Br. at 20, citing *AMA Guides, 5th Ed.*, 1.6b, p. 11). Dr. Betz verified each of these requirements and cited the underlying documentation during his expert testimony, and the Appeals Officer found that the evidence and testimony supported apportionment. (ROA 16, 63-67) The Appeals Officer further concluded that Dr. Anderson's apportionment of the Claimant's impairment as seventy-five percent (75%) non-industrial and twenty-five percent (25%) industrial was proper and credible and was confirmed by Dr. Betz's medical records review and expert testimony. (ROA 17). The Appeals Officer also noted that Dr. Betz's testimony at the hearing was uncontroverted, credible and reliable. (*Id.*) The Appeals Officer's conclusions regarding apportionment required an application of the facts to the law. These mixed determinations are entitled to deference on appeal. *See Hernandez*, 124 Nev. at 647, 188 P.3d at 1132.

Finally, as discussed in Section II *supra*, NAC 616C.490(6) does not require that the documentation of a pre-existing condition predate the industrial injury. Claimant's argument concerning Dr. Jempsa's apportionment analysis is inapposite. The Appeals Officer found Dr. Jempsa's analysis to be less credible than that of Dr. Anderson and Dr. Betz, because Dr. Jempsa did not address evidence of the pre-existing condition shown in the medical records, dated after the industrial injury, such as the January 13, 2016 MRI report. Because the Appeals Officer Decision addressed the underlying reasons for this credibility determination, it was not an abuse of discretion to give less weight to Dr. Jempsa's PPD findings.

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CONCLUSION

For the foregoing reasons, Claimant has failed to demonstrate that any of the findings of fact or conclusions of law she challenges are in error or unsupported by the substantial evidence. Further, these findings of fact and conclusions of law on mixed questions of fact and the law must be given deference. With the Appeals Officer Decision supported by the substantial evidence, Claimant's Petition for Judicial Review should be denied.

AFFIRMATION

The undersigned does hereby affirm that the preceding does not contain the social security number of any person.

DATED this 23rd day of April, 2020.

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CERTIFICATE OF COMPLIANCE

I hereby certify that I have read this **RESPONDENT'S ANSWERING 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), which requires every assertion in the brief regarding matters in the record to be supported by appropriate references to the record on appeal. 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 23rd day of April, 2020.

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CERTIFICATE OF SERVICE

I certify that I am an employee of McDonald Carano, LLP and that on the 23rd day of April, 2020, a true and correct copy of the foregoing **RESPONDENT'S ANSWERING BRIEF** was electronically filed with the Clerk of the Court by using CM/ECF, served on parties on the electronic service list for this case, and I caused a true and correct copy to be deposited with the U.S. Postal Service at Reno, Nevada addressed to the parties as follows:

Nevada Department of Administration
Appeals Division
1050 E. William Street, Suite 450
Carson City, NV 89701

/s/ Carole Davis
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IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO, and the NEVADA DEPARTMENT OF ADMINISTRATION APPEALS OFFICER,

Respondents.

Case No.: CV19-01683

Dept. No.: 4

PETITIONER'S OPENING BRIEF

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TABLE OF AUTHORITIES

NEVADA CASES

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COMES NOW the Petitioner, KIMBERLY KLINE, by and through her attorney, HERB SANTOS, JR., Esq., of THE LAW FIRM OF HERB SANTOS, JR., and hereby respectfully submits her ***Petitioner's Opening Brief*** in the above referenced matter.

Respectfully submitted this 24 day of February, 2020.

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By _____
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I. JURISDICTIONAL STATEMENT

1. Jurisdiction is conferred on the District Court pursuant to NRS 233B.130 and NRS 616C.370.

2. The Decision and Order of the Appeals Office at issue in this proceeding was filed on August 20, 2019. The Petition for Judicial Review was timely filed on August 28, 2019.

II. ISSUES PRESENTED FOR REVIEW

1. Whether the Appeals Officer's Decision and Order which reversed the Hearing Officer's Decision dated July 19, 2018 and affirming the underlying determinations dated May 24, 2018 and June 13, 2018 was the result of reversible error of law?
2. Whether the Appeals Officer committed reversible error by not following Nevada law?
3. Whether the Appeals Officer's Decision and Order finding that the Petitioner's PPD award must be apportioned 75% as pre-existing is not supported by the substantial evidence and results in an abuse of discretion?

III. STATEMENT OF THE CASE

The Petition arises out of a contested industrial insurance claim and is the result of an August 20, 2019 Decision and Order from former Appeals Officer Rajinder Nielsen, Esq. which reversed a PPD determination letter in which the Respondent apportioned 75% of the award as pre-existing. The Appeals Officer Nielsen found that the Respondent's PPD award as offered by the Respondent was correct. *ROA 3-22.*

The Petitioner's Petition seeks judicial review of the

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erroneous decision and reinstatement of the Hearings Officer's Decision. The Petitioner submits that the Decision was (a) Affected by error of law; (b) Clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; and © Arbitrary and capricious and characterized by abuse of discretion.

IV. STATEMENT OF FACTS

The Petitioner suffered an industrial injury while in the course and scope of her employment with the Respondent on June 25, 2015. *ROA 177-182.* The Petitioner was rear ended in her work vehicle by another vehicle. *ROA 177-182.* The Petitioner presented to St. Mary's Regional Medical Center for treatment. *ROA 183-186.* The initial assessment was acute lumbar radiculopathy, sprain of the lumbar spine, and acute pain in the lower back. *ROA 184.*

On June 30, 2015, the Petitioner was seen by Dr. Hall at Specialty Health. *ROA 189.* The Petitioner had complaints of neck discomfort that was described as moderate, diffuse, radiating into the right shoulder with associated stiffness and lumbar and thoracic pain. *ROA 189.* Dr. Hall assessed the Petitioner as suffering from a sprain of the neck and sprain of the lumbar region. *ROA 190.* He recommended chiropractic care, returned the Petitioner to work full duty, and advised her to return in two weeks. *ROA 190-192.*

The Petitioner received chiropractic care from Dr. Maria Brady who is also from Dr. Hall's clinic. Dr. Brady assessed that the Petitioner had spinal segment dysfunction at C6, C7, T1, T3, T4, L4, L5 and S1 that necessitated chiropractic adjusting at

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those levels. *ROA 193-195.* The Petitioner saw Dr. Brady again on July 7, 2015 and July 9, 2015, with complaints of worsening symptoms. *ROA 197-204.* Dr. Brady provided chiropractic adjustments. *ROA 197-204.*

The Petitioner returned to see Dr. Hall on July 14, 2015. *ROA 205-207.* The Petitioner continued to have ongoing lumbar and neck pain, that was moderate to severe, associated sleep disruption and stiffness, and had minimal improvement with chiropractic care. *ROA 205.* Dr. Hall recommended the Petitioner receive six physical therapy sessions. *ROA 206.*

The Petitioner began physical therapy on August 5, 2015. *ROA 209-211.* The Petitioner received physical therapy treatment from August 5, 2015 through October 26, 2015. *ROA 209-214, 220-225, 229-234, 236, 237, 288-291.* The Petitioner was discharged from physical therapy on October 26, 2015 to a home exercise program. *ROA 291.*

The Respondent issued a notice of intention to close the Petitioner's claim on November 6, 2015. *ROA 295.* This was the second time the Respondent tried to close the claim. *ROA* 219. The Respondent tried to close the claim while the Petitioner was treating on August 27, 2015. *ROA 219.*

On January 13, 2016, the Petitioner saw Dr. Hansen for chiropractic care for her neck pain. *ROA 296-298.* Dr. Hansen's assessment was that the Petitioner had cervical disc displacement, unspecified cervical region. *ROA 297.* Dr. Hansen felt that there was a high probability within a medical degree of certainty that the Petitioner's injuries were related to the rear-end collision she had recently sustained. *ROA 298.* Dr.

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Hansen recommended non-surgical spinal decompression coupled with Class IV deep tissue laser therapy four (4) times per week for four (4) weeks, undergo re-examination, and continue with care two (2) times a week for two (2) weeks pending no unforseen issues or conditions. *ROA 300.*

The Petitioner had an MRI on January 13, 2016, which revealed disc degeneration with large disc protrusions at the C5-6 and C6-7 levels resulting in complete effacement of CSF from the ventral and dorsal aspects of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia. *ROA 299.*

The Petitioner returned to see Dr. Hansen on January 14, 2016. *ROA 301-305.* Dr. Hansen referred the Petitioner to Dr. Zollinger for evaluation and treatment as she was in a significant amount of pain with numbness in her left upper extremity. *ROA 301.* Dr. Hansen reviewed the MRI which revealed two large disc protrusions at C5-6 and C6-7 with pain consistent with C5-6. *ROA 306.* He again opined that the disc protrusions were directly related to the industrial accident. *ROA 306.*

Pursuant to Hearing Number 55487-JL, the Respondent *was* ordered to forward the Petitioner's MRI results to Dr. Hall and question him accordingly. *ROA 342-344.* The Respondent was ordered to issue a new determination regarding the further disposition of the Petitioner's claim upon receipt of Dr. Hall's response. *ROA 342-343.*

The Respondent questioned Dr. Hall and on March 16, 2016 Dr. Hall responded. *ROA 345-346.* Dr. Hall opined that it was likely that Petitioner had disc degeneration prior to the industrial

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injury which may have been exacerbated by the industrial injury, but he noted no evidence of neurologic symptoms during his treatment of her industrial injuries. Dr. Hall found no objective evidence connecting the MRI findings from January 13, 2016 and the industrial injury. Notwithstanding the Petitioner's complaints, Dr. Hall opined that the Petitioner recovered completely from the industrial injury on June 25, 2015 by the end of October 2015. *ROA 345-346.*

Due to the Petitioner's ongoing complaints, she saw Dr. Sekhon on July 5, 2016 pursuant to a referral of Dr. Hansen. *ROA 241-246.* Dr. Sekhon's impression was:

1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7;
2. Mobile spondylolisthesis at C4-5;
3. Failed conservative therapy; and
4. Minimal spondylosis, L3-4, L4-5 and L5-S1. *ROA 244.*

Dr. Sekhon noted that the Petitioner stated that she never had these arm symptoms before these accidents and although she may have had preexisting spondylosis, the accident probably exacerbated her underlying stenosis. *ROA 244.* Dr. Sekhon offered to perform a C4-5, C5-6 and C6-7 anterior cervical decompression and instrumentation fusion. *ROA 244.*

On January 18, 2017, Appeals Officer Rajinder Nielsen, Esq., entered a Decision and Order which reversed claim closure without a PPD evaluation or rating and ordered the Respondent to rescind claim closure and provide the medical treatment recommended by Dr. Sekhon. *ROA 167-176.*

Respondent timely appealed the Decision and Order to the District Court and a Petition for Judicial Review was ensued.

On December 11, 2017, the Honorable Lynne Simons issued an

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order denying the Petition for Judicial Review. *ROA 373-387.* The Court noted that the Appeals Officer gave the opinions of Dr. Hall no weight as it pertained as to the scope of the claim and that Dr. Hall's opinions were inconsistent with the medical evidence. *ROA 384.* This decision was not appealed.

The Petitioner completed her treatment and was eventually determined to be at maximum medical improvement. The Petitioner was scheduled for a PPD evaluation to determine the extent of her impairment due to her industrial injury pursuant to NRS 616C.490.

The Petitioner was seen by Russell Anderson, DC. Dr. Russell found a 25% whole person impairment. *ROA 250-256.* Dr. Russell stated that the MRI findings were not caused by the car accident. *ROA 555.* Dr. Russell then apportioned out 75% of the award which reduced the award from 25% to 6%. *ROA 256.* The Respondent then offered the Petitioner the 6% PPD award on December 5, 2017. *ROA 362.*

The determination was timely appealed by the Petitioner on December 13, 2017.

The Hearing Officer in HO 1801761-JL found a medical question pursuant to NRS 616C.330 and ordered a second PPD. *ROA 164-167.* This was appealed by the Respondent.

The Respondent filed a motion for stay on February 14, 2018, *ROA 1940-1941.*

The Petitioner filed her Opposition on March 1, 2018. *ROA 1740-1936.*

Appeals Officer Nielsen granted the stay on March 9, 2018. *ROA 1738-1739.*

On March 13, 2018, Appeals Officer Nielsen ordered a

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telephone conference between the parties and set it on March 23, 2018. *ROA 1736-1737.*

After the telephone conference, Appeals Officer Nielsen entered an order where she rescinded the prior order granting the stay. *ROA 1734-1735.*

On June 13, 2018, Appeals Officer Nielsen ordered a telephone conference between the parties and set it on July 11, 2018. *ROA 1720.*

Pending the Appeal, Appeals Officer Nielsen ordered a second PPD examination. The Claimant underwent the second PPD on May 8, 2018 with Dr. James Jempsa. *ROA 605-616.* Dr. Jempsa found a 27% whole person impairment. *ROA 616.* Dr. Jempsa did not apportion the rating. The Insurer questioned Dr. Jempsa as to why he did not apportion the rating. Dr. Jempsa provided his reasoning. *ROA 617.*

The Respondent then sought a review by Dr. Jay Betz. Dr. Betz agreed with Dr. Anderson and supported his opinion based upon Dr. Hall's opinion of March 16, 2016. *ROA 619-624.*

On June 13, 2018, the Respondent issued a determination letter offering the Petitioner a 6% PPD award. *ROA 618.* This was timely appealed by the Petitioner.

A hearing was held on July 12, 2018. The Hearing Officer found that no evidence had been presented to justify a 75% apportionment and the Claimant is entitled to the 27% PPD award by Dr. Jempsa. *ROA 601-603.* The Respondent timely appealed and the Appeals Officer reversed the hearing officer's decision. *ROA 1-22.*

During the Appeals Hearing, Dr. Betz conceded the following

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conclusive facts:

1. Dr. Betz was unable to apportion what pain was related to degenerative changes versus what was caused by the C5/6 and C6/7 herniations which were causing cord compression. *ROA 83.*
2. Dr. Betz conceded that if the C5/6 and C6/7 protrusions were caused by the industrial accident, it would change his opinion on apportionment. *ROA 86.*
3. Dr. Betz conceded that there was no evidence of a ratable impairment of the cervical spine prior to the industrial accident. *ROA 87.*
4. Dr. Betz confirmed that there were no prior records that supported an impairment to the cervical spine prior to the industrial injury. *ROA 88.*
5. Dr. Betz confirmed that there were no prior medical opinions that supported an impairment to the cervical spine prior to the industrial injury under the AMA Guides, 5th Edition. *ROA 88.*
6. Dr. Betz confirmed that there is not one medical record that documents that the Petitioner had prior pre-industrial accident symptoms for her cervical spine. *ROA 94.*
7. Dr. Betz confirmed that there is not one medical record that the Petitioner would have ever needed to have a cervical fusion surgery prior to the industrial accident. *ROA 95.*
8. Dr. Betz conceded that under the AMA Guides, 5th Edition, the rating doctor has to assess whether a

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condition was ever symptomatic and whether there was an aggravation and both he and Dr. Anderson found no evidence that any cervical pre-existing condition was ever symptomatic prior to the industrial accident. *ROA 98.*

9. Dr. Betz conceded that the PPD completed by Dr. Jempsa (27%) is correct on apportionment if the disc protrusions were caused by the industrial accident. *ROA 106.*

V. ARGUMENT

A. ARGUMENT SUMMARY

The Petitioner seeks the Court to reverse the Appeals Officer's Decision because it contends that the decision is procedurally deficient and is the result of reversible error. The Appeals Officer ignored the rules related to apportionment and relied on opinions which were previously determined, by this same Appeals Officer, to be untrustworthy. The Petitioner notes that the Appeals Officer specifically stated in her prior decision that

> "I also found the opinions of Dr. Sekhon and Dr. Hansen to be well reasoned. I specifically give more weight to the opinions of Dr. Sekhon and Dr. Hansen as opposed to Dr. Hall as the objective medical evidence supports Dr. Sekhon's and Dr. Hansen's medical expert opinions." *ROA 172.*
>
> "The substantial evidence supports a finding that the industrial accident aggravated the pre-existing condition and the resulting condition was the substantial contributing cause of the resulting condition. I found Dr. Hall's opinions to be inconsistent with the medical evidence and he failed to state his opinion(s) within a reasonable degree of medical probability. Therefore I give his opinions no weight." *ROA 174.*
>
> "Without evidence of a subsequent injury, I find that the condition claimed by the Claimant are casually related to

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the subject industrial accident." *ROA 174.*

> "...the Claimant's industrial condition are not MMI and provide all appropriate benefits to the Claimant as authorized by Nevada law for the C4-5, C5-6 and C6-7 cervical discs, including but not limited to the surgical recommendation by Dr. Sekhon, i.e., a C-4-5, C5-6 and C6-7 anterior cervical decompression and instrumentation fusion." *ROA 174-175.*

The Appeals Officer documented those objective medical findings in her prior decision but now, in the instant matter, relies on Dr. Betz who disagrees with those findings.

The substantial evidence of the record establishes that the Petitioner did not have any pre-injury impairment under the AMA Guides, 5th Edition. Apportioning the rating by 75% when it has already been determined that the industrial injury was the substantial contributing factor for the resulting condition is inconsistent. Further, the rules on apportionment are clear and unambiguous and clearly instruct a rating physician or chiropractor that under the facts of this case, there would be no apportionment.

B. STANDARD OF REVIEW

A petition for judicial review is allowed pursuant to NRS 233B.135 which states:

> 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

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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.

(Added to NRS by 1989, 1650)

The district court has broad supervisory powers to ensure that all relevant evidence is examined and considered by the appeals officer and that the findings and ultimate decisions of the appeals officer are not disturbed unless they were clearly erroneous or otherwise amounted to an abuse of discretion. ***Nevada Indus. Comm'n v. Reese***, 93 Nev. 115, 560 P.2d 1352 (1977), ***State Indus. Ins. Sys. v. Snapp***, 100 Nev. 290, at 294, 680 P.2d 590 (1984), ***Stark v. State Indus. Ins. Sys.***, 111 Nev. 1273, at 1275, 903 P.2d 818 (1995), ***State Indus. Ins. Sys. v. Hicks***, 100 Nev. 567, at 569, 688 P.2d 324 (1984), ***State Indus. Ins. Sys. v. Swinney***, 103 Nev. 17, at 20, 731 P.2d 359 (1987), ***State Indus. Ins. Sys. v. Christensen***, 106 Nev. 85, at 88, 787 P.2d 408 (1990), ***Brown v. State Indus. Ins. Sys.***, 106 Nev. 878, at 880, 803 P.2d 223 (1990), ***Maxwell v. State Indus. Ins. Sys.***, 109 Nev. 327, at 331, 849 P.2d 267 (1993); ***Ayala v. Caesar's Palace***, 119 Nev. 232, at 240, 71 P.3d 490 (2003). Under the standard of review for appeals, if factual findings of the agency are supported by evidence, they are conclusive and reviewing the court's jurisdiction is confined to questions of law. (See NRS

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233B.135 and 612.530.) ***State, Employment Security Dep't v. Nacheff***, 104 Nev. 347, 757 P.2d 787 (1988), cited, ***Whitney v. State, Dep't of Employment Security***, 105 Nev. 810, at 812, 783 P.2d 459 (1989). In the context of judicial review of the actions of an administrative board or the determination of a trier of fact, "substantial evidence" is that which a reasonable mind might accept as adequate to support a conclusion.

The review of the District Court is confined to the record and the court is precluded from substituting its own judgment for that of the Appeals Officer as to weight of evidence on questions of fact. ***Nevada Indus. Comm'n v. Williams***, 91 Nev. 686, 541 P.2d 905 (1975), ***State Indus. Ins. Sys. v. Swinney***, 103 Nev. 17, at 20, 731 P.2d 359 (1987), ***Palmer v. Del Webb's High Sierra***, 108 Nev. 673, at 686, 838 P.2d 435 (1992). The court's review is limited to a determination of whether the Appeal's Officer acted arbitrarily or capriciously, and where there was substantial evidence to support the decision, the court can not substitute its own judgment for that of the Appeal's Officer. ***Construction Indus. Workers' Comp. Group v. Chalue***, 119 Nev. 348, at 352, 74 P.3d 595 (2003), ***Meridian Gold Co. v. State***, 119 Nev. 630, at 633, 81 P.3d 516 (2003), ***State v. Public Employees' Ret. Sys.***, 120 Nev. 19, at 23, 83 P.3d 815 (2004).

In the present case, the review of the Appeals Officer's Decision is to determine whether she complied with the mandates of NRS 233B.125. In addition, the Petitioner will also show that she incorrectly interpreted Nevada law, which is a question of law and is subject to a de novo review and that there are factual errors in her Decision which would be reviewed under the

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substantial evidence standard.

C. THE APPEALS OFFICER COMMITTED REVERSIBLE ERRORS OF LAW.

There are two areas where the Appeals Officer committed reversible error of law.

1. THE APPEALS OFFICER RE-LITIGATED FACTS WHICH SHE PREVIOUSLY DECIDED IN A PRIOR APPEAL.

The Appeals Officer essentially finds that the cervical discs were pre-exiting based upon Dr. Anderson's PPD and Dr. Betz' review. Both of these doctors stated that the herniations were not caused by the subject accident. The Appeals Officer previously found that Dr. Hansen stated that there was a high probability within a degree of medical certainty that the Petitioner's injuries are related to the rear end motor vehicle accident. *ROA 170*. Dr. Hansen then ordered an MRI. After reviewing the MRI he opined that the

> "MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision." *ROA 306*.

The Appeals Officer has essentially re-opened the door on the scope of the claim which was already decided in AO 56832-RKN. The Appeals Officer previously found that Dr. Hall's opinions were inconsistent with the medical records. She also found that his opinions did not meet the legal standard. A testifying physician must state to a degree of reasonable medical probability that the condition in question was caused by the industrial injury, or sufficient facts must be shown so that the trier of fact can make the reasonable conclusion that the condition was caused by the industrial injury. ***United Exposition***

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Co. v. SIIS, 109 Nev. 421, 851 P.2d 423, 425 (1993). The Appeals Officer found that the opinions of Dr. Hall were not stated within a reasonable degree of medical probability. *ROA 174*. Given that she also found that Dr. Hall's opinions were inconsistent with the medical records, it is reasonable to conclude that any subsequent opinion by a rating physician should also be bound to those findings. *ROA 174*. Dr. Hall confirmed that the only records he reviewed and was provided by the Respondent was a visit to the chiropractor dated January 13, 2016 and the MRI dated January 13, 2016. *ROA 345*. The Respondent failed to provide Dr. Hall with the medical records through March 16, 2017 which would have been medical reports with Dr. Hansen for the following dates: January 14, 2016 (*ROA 300-305*), January 15, 2016 (*ROA 307-308*), January 18, 2016 (*ROA 309-310*), January 19, 2016 (*ROA 311-312*), January 20, 2016 (*ROA 313-314*), January 21, 2016 (*ROA 315-316*), January 25, 2016 (*ROA 317-318*), January 26, 2016 (*ROA 319-320*), January 27, 2016 (*ROA 321-322*), January 28, 2016 (*ROA 323-324*), February 1, 2016 (*ROA 325-326*), February 2, 2016 (*ROA 326-327*), February 5, 2016 (*ROA 328-329*), February 8, 2016 (*ROA 330-331*), February 10, 2016 (*ROA 331-332*), February 12, 2016 (*ROA 333-334*), February 16, 2016 (*ROA 334-336*), February 19, 2016 (*ROA 336-337*) and February 24, 2016 (*ROA 337-339*). The Respondent had requested all medical bills from Dr. Hansen on February 22, 2016. *ROA 1045*. At a minimum, the Respondent had all records from January 13, 2016 through January 21, 23016 as they time stamped the documents received on January 25, 2016. *ROA 1030-1043*. The Respondent failed to provide Dr. Hall with these records which is one of the reasons which supports the Appeals

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Officer's Decision that Dr. Hall's opinions were inconsistent with the medical records.

In addition, the Appeals Officer found that the Respondent continued to complain of cervical pain but "was released by Dr. Hall, notwithstanding her complaints." *ROA 173*. The record also clearly confirms that Dr. Hall never ordered any diagnostic studies to determine the extent and or cause of her symptoms. *ROA 173*.

Dr. Hall also stated that there "was no evidence of neurologic symptoms during treatment of the industrial injury noted by myself or her physical therapist." *ROA 345*. This is another example of Dr. Hall's statements being inconsistent with the medical records. At the Respondent's very first evaluation by Dr. Hall, he notes "Neck discomfort - moderate, diffuse, radiation into the right shoulder, associated stiffness." *ROA 189*.

The Respondent also received physical therapy while under Dr. Hall's care. The physical therapy records confirm tenderness and tightness noted over various muscles controlled by the cervical spine (cervical paraspinais, suboccipitals, scalenee and upper trapezius). *ROA 209, 218, 229, 231 and 233*. The records also document complaints of pain in the shoulder area. *ROA 209, 224 and 233*.

Dr. Hall also fails to discuss the chiropractic treatment the Respondent received from his own facility. According to Dr. Maria Brady, on July 1, 2015, there was spinal segmental dysfunction at C-6 and C-7. *ROA 195*. This was also noted at her July 7, 2015 *(ROA 200)* and July 9, 2015 visit *(ROA 202)*. At each

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visit, Dr. Brady adjusted her spine at those levels.

It is also interesting to note that Dr. Hall only saw the Respondent a total of five times from June 30, 2015 through October 28, 2015. *ROA 189-192, 205-207, 215-216, 226-228 and 292-294.*

The Appeals Officer noted this treatment by Dr. Brady, Dr. Hall and P.T. Bruesewitz in her decision. *ROA 169-170.* Respondent submits that the medical records submitted provides overwhelming evidence to support a finding to give little or no weight to the opinions of Dr. Hall.

The Findings of Facts and Conclusions of Law set forth in the Appeals Officer's Decision clearly document her failure to consider her prior findings and conclusions. In the present matter, her opinions are now based on faulty information.

2. THE APPEALS OFFICER DID NOT APPLY NAC 616C.490 AND NRS 616C.490.

Nevada has adopted the ***AMA Guides to the Evaluation of Permanent Impairment, 5th Edition*** [hereinafter referred to as the "***AMA Guides***"] ***NRS 616C.110*** The ***AMA Guides*** was originally published in 1971 to establish "a standardized, objective approach to evaluating medical impairments" for purposes of workers' compensation benefits. ***AMA Guides***, supra, § 1.1, at 1. The ***AMA Guides*** set forth impairment criteria that certified rating physicians and chiropractors are able to use to evaluate injured workers and give them an "impairment percentage or rating." ***Id.*** § 1.2, at 4.

Impairment ratings reflect functional limitation, rather than disability, and demonstrate the severity of the medical

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condition and the "degree to which the impairment decreases an individual's ability to perform common activities of daily living." ***NAIW v. Nevada Self-Insured Association***, 126 Nev. Advanced Opinions 7, page 2 (2010).

Apportionment of a pre-existing condition for a PPD is required under Nevada law. NRS 616.490(9) states:

> "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."

In addition, the Nevada Administrative Code provides specific guidelines for apportionment of pre-existing conditions. The applicable code states in pertinent part:

> **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 9, 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 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 impairment if the percentage of impairment established for his 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.
>
> . . .
>
> 5. Except as otherwise provided in subsection 6, if a rating evaluation was completed in another state for a previous injury or disease involving a condition, organ or anatomical structure that is identical to the condition,

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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 determined by using the Guide, 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.

6. If precise information is not available, and the rating physician or chiropractor is unable to determine an apportionment using the Guide as set forth in subsection 5, 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.

7. If there are preexisting conditions, including, without limitation, degenerative arthritis, rheumatoid variants, obesity or congenital malformations, 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.

8. 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.

9. If no documentation exists pursuant to subsection 7 or 8, 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) [Emphasis added]

The requisite determination of the rating physician is to determine the "scope and the nature of the impairment which existed before the industrial injury or the onset of disease." NAC 616C.490(7). The ***AMA Guides*** also provides specific instruction for apportionment. According to the ***AMA Guides***, an

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apportionment analysis represents a distribution or allocation of causation among multiple factors that caused or significantly contributed to the injury or disease and resulting impairment. ***AMA Guides, 5th Ed.***, *1.6b, page 11*. Before determining apportionment, the physician needs to verify that all of the following information is true for an individual:

1. There is documentation of a prior factor.
2. The current permanent impairment is greater as a result of the prior factor (i.e. prior impairment, prior injury, or illness).
3. There is evidence indication the prior factor caused or contributed to the impairment, based upon a reasonable probability. ***Id.***, *at page 11*.

According to the ***AMA Guides***, the apportionment analysis must consider the nature of the impairment and its possible relationship to each alleged factors. Most important is that the rating physician must provide an explanation of the medical basis for all of the conclusions and opinions regarding apportionment. The most recent impairment rating is calculated and then the prior impairment is calculated and deducted.[1] ***Id.***, *at page 12*.

The ***AMA Guides*** must be followed and a rating physicians

---

[1] The ***AMA Guides*** provides the following example:

> "...in apportioning a spine impairment rating in an individual with a history of a spine condition, one should calculate the current spine impairment. Then calculate the impairment from any pre-existing spine problem. The preexisting impairment rating is then subtracted from the present impairment rating to account for the effects of the former. This approach requires accurate and comparable data for both impairments."

Another example is given on page 20 of the book entitled ***Master the AMA Guides, Fifth***.

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report must not be left to speculation and guesses. There is no evidence that the Claimant had any ratable impairment at the time of her current industrial injury. Dr. Jempsa found this and Dr. Betz had to concede that fact during his testimony. Scientific methodology must be followed otherwise the rating physician opinion cannot meet the reasonable degree of medical certainty standard. This methodology requires an apportionment analysis as set forth in the ***AMA Guides***. Without such an analysis, apportionment is not warranted. Further, the clear and unambiguous language of NRS 616C.490(1) is mandatory. The rating physician **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. NRS 616C.490(1) Without the proper apportionment analysis required by both Nevada law and the ***AMA Guides***, prior medical records confirming that there was a rateable, prior residual impairment, and proof of a residual impairment at the time of the industrial injury [which would be rateable under the ***AMA Guides***], there can be no reasonable, substantiated apportionment.

After reviewing the numerous prior records which did not document any problems with the Claimant's cervical spine, Dr. Jempsa states apportionment is not appropriate. *ROA 617*. NRS 616C.490 requires that there be evidence that a rateable impairment (as defined in the ***AMA Guides***) existed on the date of the industrial injury for apportionment to occur. NAC 616C.490 clarifies the nature and quantum of medical evidence necessary to sustain an apportionment. In this case there is no evidence that

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a rateable impairment existed on the date of the industrial injury. Dr. Betz concedes that there is no documentation concerning the scope and the nature of the impairment which existed before the industrial injury. *ROA 87,88 and 94.* Nevada law is clear that if there is no documentation which exists to establish an impairment which existed on the date of the industrial injury, the impairment may not be apportioned. NAC 616C.490(8)

The Appeals Officer committed error of law by not applying NAC 616C.490 and NRS 616C.490. It is undisputed that at the time of the industrial accident, the Petitioner had a 0% impairment due to any pre-existing condition that she may have had. Apportioning almost the entire award as pre-existing (75%) is a complete departure from Nevada law on apportionment of PPD ratings.

D. THE APPEALS OFFICER'S DECISION AND ORDER TO REVERSE THE HEARING OFFICER'S DECISION IS NOT SUPPORTED BY SUBSTANTIAL EVIDENCE.

In determining whether a decision is arbitrary and capricious, the decision will be reviewed in light of the "reliable, probative, and substantial evidence on the whole record." NRS 233B.135(3)(e).

The Appeals Officer's findings of fact are not supported by substantial evidence.

1. THE APPEALS OFFICER ABUSED HER DISCRETION WHEN SHE AGREED WITH THE 75% APPORTIONMENT OF THE PPD AWARD WHICH WAS BASED ON THE DISK HERNIATIONS NOT BEING INDUSTRIALLY CAUSED.

This finding is not consistent with the medical reporting which was admitted into evidence and the same Appeal Officer's

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prior decision in which she found that the disk herniations were industrially caused. The opinions on apportionment are based upon the misguided reliance on Dr. Hall's opinions which the Appeals Officer previously gave no weight and found to be inconsistent with the medical evidence. The Appeals Officer's prior Decision found that Dr. Hall's opinion, due to his inconsistent records coupled with the Respondent's failure to provide him with all of the medical records and along with speculative opinion that was not stated within a reasonable degree of medical probability, were given no weight. How can those same opinions which were the basis for the apportionment opinions of Dr. Anderson and Dr. Betz be trustworthy? This is where the Appeals Officer abused her discretion. She disregarded her prior findings and what became the law of the case (scope of the claim) and disregarded an opinion which was consistent with her prior findings and supported her decision on opinions that were based on facts which the Appeals Officer previously found were inconsistent, not reliable and incorrect.

Dr. Betz was clear that if the disc protrusions were caused by the industrial accident, then the PPD completed by Dr. Jempsa (27%) is correct. *ROA 106.* Because the disc protrusions were found to be industrially related, it was an abuse of discretion to not accept Dr. Jempsa's PPD findings.

For these reasons, the Petitioner's Petition for Judicial Review should be granted due to the Appeals Officer's abuse of discretion.

VI. CONCLUSION

The Appeals Officer's Decision does not meet the

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requirements of NRS 233B.125. The Appeals Officer committed reversible errors of law by not applying NAC 616C.490 and NRS 616C.490. The Appeals Officer's Decision is also erroneous in view of the reliable, probative and substantial evidence on the whole record and results in an abuse of discretion as alleged by the Petitioner. Finally, the Appeals Officer's refusal to take into account her prior Decision renders a re-litigation of the scope of the claim which is another reversible error of law.

WHEREFORE, the Petitioner respectfully asks that the Court grant the Petitioner's request for Judicial Review, reverse the Appeal's Officer's Decision and reinstate the Hearing Officer's Decision, instructing the Respondent to offer the Petitioner the 27% PPD award.

Respectfully submitted this 24 day of February, 2020.

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By _____
HERB SANTOS, JR., Esq.
Attorney for Petitioner

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VII. CERTIFICATE OF COMPLIANCE

I, HERB SANTOS, JR., ESQ., 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 the applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e), which requires every assertion in the brief regarding matters in the record to be supported by appropriate references to the record on appeal. 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.

Respectfully submitted this 24 day of February, 2020.

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VIII. AFFIRMATION

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby certify that the preceding document, ***RESPONDENT'S REPLY BRIEF***, filed in case number CV19-01683, does not contain the social security number of any person.

Respectfully submitted this 24 day of February, 2020.

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IX. CERTIFICATE OF MAILING

Pursuant to N.R.C.P. 5(b), I hereby certify that I am over the age of eighteen years, and that on this date I electronically filed the foregoing document using the ECF system which will send notice of filing to

Lisa Whiltshire-Alstead, ESQ.

I also hereby certify that I deposited for mailing at Reno, Nevada a true and correct copy of the foregoing document addressed to:

Lisa Wiltshire Alstead, Esq. MCDONALD CARANO, LLP 100 West Liberty Street, 10th Floor Post Office Box 2670 Reno, Nevada 89505-2670	CITY of RENO Risk Management P.O. Box 1900 Reno, Nevada 89505
CCMSI Attn: Lisa Jones P.O. Box 20068 Reno, Nevada 89515-0068	Rajinder Nielsen, Esq., Appeals Officer Nevada Department of Administration 1050 E. William Street, Suite 450 Carson City, NV 89701
Michelle Morgando, Esq., Sr. Appeals Officer Nevada Department of Administration 2200 S. Rancho Drive, Suite 220 Las Vegas, NV 89102	Patrick Gates, Director Nevada Department of Administration 515 E. Musser Street, Suite 300 Carson City, NV 89701
Aaron Ford, Esq. Office of the Attorney General 100 N. Carson Street Carson City, NV 89701	

DATED this 24 day of February, 2020.

Jimayne Lee

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CITY OF RENO AND CANNON
COCHRAN MANAGEMENT SERVICES, INC.

IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

* * * * *

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO, ESQ., Sr. Appeals Officer; RAJINDER NIELSEN, ESQ., Appeals Officer, ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

Case No.: CV19-01683

Dept. No.: 4

STAEMENT OF INTENT TO PARTICIPATE

COMES NOW, pursuant to NRS 233B.130(3), Respondents CITY OF RENO ("CITY") and CANNON COCHRAN MANAGEMENT SERVICES, INC. ("CCMSI")[1], hereby notify the

[1] The City is a self-insured employer. CCMSI, the City's third-party administrator, was not a party to the Appeals Officer hearing and is not a real party in interest. This statement of intent to participate identifies CCMSI out of an abundance of caution; however, CCMSI hereby objects, and reserves its right to challenge, Petitioner improperly naming it as a respondent in this matter.

parties of their intent to participate in the above-entitled Petition for Judicial Review filed by Petitioner on August 28, 2019.

AFFIRMATION
(Pursuant to NRS 239B.030)

The undersigned does hereby affirm that the preceding does not contain the social security number of any person.

DATED this 9th day of September, 2019.

McDONALD CARANO LLP

By: _____

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 9th day of September, 2019, I served the within **STATEMENT OF INTENT TO PARTICIPATE** upon all parties registered for electronic service through filing with the Clerk of the Court by using the Court's CM/ECF system. I also caused a true and correct copy of the foregoing to be deposited with the U.S. Postal Service, postage prepaid, and mailed upon the following parties:

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IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO, ESQ., Sr. Appeals Officer; RAJINDER NIELSEN, ESQ., Appeals Officer, ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

Case No.: CV19-01683

Dept. No.: 4

PETITION FOR JUDICIAL REVIEW

The Petitioner, KIMBERLY KLINE, by and through her attorney, Herb Santos, Jr., Esq., of The Law Firm of Herb Santos, Jr., hereby petitions this court for judicial review of the Order rendered and filed by the Department of Administration Appeals Officer on August 20, 2019 for Claim No. 15853E839641, under Appeal Nos. 1900471-RKN, 1902049-RKN and 1802418-RKN. A copy of the Order is attached hereto as Exhibit 1.

The grounds upon which this review is sought are:

1. The Order rendered by the Appeals Officer prejudices substantial rights of the

Petitioner because it is:

a. affected by error of law;

b. clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; and

c. arbitrary and capricious and based upon an abuse of discretion by the Appeals Officer.

WHEREFORE, Petitioner prays as follows:

1. The court grants judicial review of the Order filed on August 20, 2019 by the Department of Administration Appeals Officer;

2. The court vacate and set aside the Order issued by the Appeals Officer; and

3. For such other and further relief as the court deems just and proper.

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby certify that the preceding document, **PETITION FOR JUDICIAL REVIEW**, filed in the Second Judicial District Court of the State of Nevada, does not contain the social security number of any person.

Respectfully submitted this 24 day of August, 2019.

THE LAW FIRM OF HERB SANTOS, JR.
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Reno, Nevada 89501

By: _____
HERB SANTOS, JR., ESQ.

CERTIFICATE OF SERVICE

Pursuant to N.R.C.P. 5(b), I hereby certify that I am an employee of THE LAW FIRM OF HERB SANTOS, JR. and that on this date, I electronically filed the foregoing document using the ECF system and that on this date I served a true and correct copy of the foregoing document via U.S. Mail to the following:

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DATED this 28 day of August, 2019.

Jimayne Lee

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EXHIBIT 1

EXHIBIT 1

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
APPEALS DIVISION

In the Matter of the Contested Industrial Insurance Claim of:

KIMBERLY KLINE,

Claimant.

Claim No.: 15853E839641

Hearing Nos.: 1803718-JL
1803717-JL
1901522-JL

Appeal Nos. 1900471-RKN
1902049-RKN
1802418-RKN

APPEALS OFFICER DECISION

An appeal hearing was conducted on May 1, 2019. Claimant Kimberly Kline ("Claimant") was represented by Herb Santos, Jr. of the Law Firm of Herb Santos, Jr. The self-insured employer City of Reno ("Employer") was represented by Lisa Wiltshire Alstead of the law firm McDonald Carano, LLP. The hearing was conducted pursuant to Chapters 616A through 617 and 233B of the Nevada Revised Statutes.

The issues presented in this appeal include:

1. **AO1900471-RKN** – The Employer's appeal of the July 19, 2018 Hearing Officer Decision reversing the Employer's third-party administrator's May 24, 2018 and June 13, 2018 determination letters. The May 24, 2018 determination letter notified Claimant that Dr. Jempsa's permanent partial disability ("PPD") rating of 27% was being held in abeyance. The June 13, 2018 determination letter offered Claimant a 6% PPD award based on Dr. Betz's reporting agreeing with Dr. Anderson's reporting as to appointment and offering a 6% PPD award. The Hearing Officer Decision reversed these decisions finding no medical evidence to justify a 75% apportionment.

2. **AO1902049-RKN** – Claimant's appeal of the December 27, 2018 Hearing Officer Decision affirming and remanding Employer's third-party administrator's September 20,

2018 determination letter offering the undisputed 6% PPD award in lump sum or installments and 21% in monthly installments pursuant to NRS 616C.380.

3. **AO1802418-RKN** – The Employer's appeal of the January 16, 2018 Hearing Officer Decision remanding the December 5, 2017 determination letter awarding a 6% PPD award. The Hearing Officer found a medical question on apportionment and ordering a second PPD evaluation under NRS 616C.330.

The evidence presented at hearing consisted of 14 separate multipage exhibits identified as Exhibits 1 through 4 (previously admitted in Appeal No. 1802418-RKN) and Exhibits A through J marked and entered into evidence at the time of hearing. Witness testimony was provided by Claimant. Jay Betz, M.D. was qualified as an expert and provided expert testimony. Having reviewed the documentary evidence submitted by the parties, considered the witness and expert testimony at the appeal hearing, and considered the arguments of counsel, the Appeals Officer makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

The Claimant worked as a parking enforcement officer for the City. On June 25, 2015, the Claimant was injured when her work vehicle was rear ended by another vehicle. (Ex. 2, pp. 4-6.) This was her second motor vehicle accident within a month, the first of which occurred on or around June 3, 2015. (Ex. 2, p. 16.) Claimant's prior injury from the first accident was nearly resolved at the time of the second injury. [1] (Ex .2, p. 16.)

The Claimant was treated at St. Mary's Regional Medical Center for back and neck pain. (Ex. 2, pp. 16-18.) She was diagnosed by Dr. Richard Law with an acute lumbar radiculopathy, sprain of the lumbar spine, and acute pain the lower back. (Ex. 2, p. 17.) On July 23, 2015, the claim was accepted for cervical strain. (Ex. 2, p. 60.) The Claimant received medical treatment with Scott Hall, M.D. in addition to chiropractic care and physical therapy. (*See generally* Ex. 2.)

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[1] In AO 56832-RKN, this Court found that the Claimant's industrial claim was closed prematurely. (Ex. 1, pp. 161-170.)

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On October 28, 2015, Dr. Hall found the Claimant's condition at maximum medical improvement, stable not ratable, and released her to full duty with no restrictions. (Ex. 2, p. 97.)

On January 13, 2016, the Claimant underwent an MRI, which found disc degeneration with large disc protrusions at the C5-C6 levels resulting in complete effacement of CSF from the ventral and dorsal aspects of the cord with severe canal stenosis. (Ex. 2, p. 110.) In AO 56832-RKN, this Court specifically found that Dr. Hansen specifically opined that the "MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision." (Ex. 1, p. 167.)

On March 16, 2016, Dr. Hall noted that there was no evidence of neurologic involvement after the June 25, 2015 accident, specifically stating that the new onset of severe symptoms started quite suddenly and it is uncertain if there is any relation to the industrial injury, also noting that the Claimant sought treatment from an orthopedist prior to the June 2015 injury. (Ex. 2, pp. 151-152.) Finally, Dr. Hall noted that all indications were that the Claimant had completely recovered from the industrial injury by the end of October, 2015. (*Id.*)

On July 5, 2016, the Claimant saw Lali Sekhon, M.D. who recommended a C4-C5 to C6-7 decompression and fusion surgery. (Ex. 1, pp. 78-83.) On June 12, 2017, Dr. Sekhon performed a C4-5, C5-6, and C6-7 anterior cervical decompression, interbody fusion. (Ex. I, p. 126.) On September 11, 2017, Dr. Sekhon determined that Claimant reached maximum medical improvement, released her to full duty, and she was ratable. (Ex. A, p. 148.)

On November 10, 2017, Dr. Russell Anderson conducted a PPD evaluation. (Ex. 2, pp. 165-171.) Dr. Anderson concluded that the Claimant has a 25% whole person impairment from the cervical spine. (*Id.* at 171.) Dr. Anderson's report further stated the Claimant had underlying cervical spine issues that pre-date this work-related car accident and injury, specifically addressing an MRI on January 3, 2016, and radiograph reports which show cervical spine degenerative discs with large protrusions at C5-6, C6-7, effacement of the CSF and severe canal stenosis. (*Id.*) Dr. Anderson stated, "It is not logical to believe that these findings are related to the car accident she

was involved in 6 months earlier." (*Id.* at 170.) Thus, 75% of the impairment was apportioned as non-industrial. (*Id.* at 180-171.)

The 25% of the Claimant's impairment that was apportioned as industrial was concluded as such because: (i) the Claimant had no documented cervical spine injury or pain immediately after the accident (symptoms began June 30, 2015), after that, the cervical strain could be described as slight; (ii) the findings of cervical spine spondylosis, stenosis, and disc bulges cannot be logically attributable to this car accident/ work injury. These findings provided the indication for fusion surgery in the cervical spine; and (iii) the Claimant had responded well to physical therapy and medical treatment and had nearly completely resolved her cervical spine complaints prior to December, 2015, and she had no upper extremity symptoms at the time of release from care. (*Id.* at 170.)

Finally, Dr. Anderson's report acknowledges that the Claimant denies any prior upper extremity symptoms before this injury, however, this work injury likely played some role in the onset of symptoms that led to surgery, but was not the primary cause. (*Id.*) Based on Dr. Anderson's review, 75% of the impairment was apportioned as non-industrial. (*Id.*) As such, he concluded that Claimant has a 6% whole person impairment related to the June 25, 2015 industrial injury. (*Id.*) Dr. Anderson is found to be credible and his reporting reliable.

On December 5, 2017, the third-party administrator issued a determination letter awarding a 6% PPD award based on Dr. Anderson's PPD evaluation. (Ex. 2, p. 175.) The Claimant appealed this determination and a hearing was conducted by the Hearing Officer on January 10, 2018. On January 16, 2018, the Hearing Officer entered a Decision and Order remanding the determination finding a medical question regarding Dr. Anderson's 75% apportionment and ordering a second PPD evaluation. The Employer appealed this determination and requested a stay.

A stay was initially entered. It was subsequently lifted and a second evaluation ordered. (Order, 3/27/18, Appeal No. 1802418-RKN.) James Jempsa, M.D. conducted the second PPD evaluation on May 8, 2018. (Ex. G, p. 13.) Dr. Jempsa found a 27% whole person impairment and failed to address apportionment. (Ex G, p. 13.) Because apportionment was not addressed,

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the third-party administrator sent a follow up request that Dr. Jempsa review Dr. Anderson's PPD evaluation and address apportionment. (*See* Ex. G, p. 26.) On May 18, 2018, Dr. Jempsa provided an Addendum which stated, "You will need to contact Dr. Anderson concerning his rationale for apportionment. . . the Claimant stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. I have not received any medical records prior to the industrial injury. . . it is my opinion that apportionment is not necessary in this case." (*See id.*) Dr. Jempsa is found to not be credible and his report is not given any weight. Dr. Jempsa failed to consider Claimant's preexisting conditions as evidenced in the medical reporting.

Subsequently, the third-party administrator sought a records review by Jay Betz, M.D. On May 24, 2018, third-party administrator sent notice out to the Claimant that it is holding the PPD award in abeyance pending Dr. Betz's review. The Claimant appealed this determination and it is the subject of this appeal.

On June 4, 2018, Dr. Betz provided his review. (Ex. H, pp. 6.) Dr. Betz noted that both Dr. Anderson and Dr. Jempsa agreed there is 12% whole person impairment utilizing Table 15-7 and that there was a 1% whole person impairment for sensory deficit in the left C6 distribution. (Ex. G at p. 4.) However, there was a large discrepancy between the active range of motion findings. Dr. Betz continued on stating that Dr. Jempsa provided no discussion or explanation for the substantial variation, and it is well recognized that patients learn from prior rating experiences, particularly when findings are "under the influence of the individual," such as active range of motion. (Ex. G. at p. 4.) Dr. Betz states that, absent an objective basis for the variation, Dr. Anderson's range of motion findings should have priority. (Ex. G. at p. 5.)

Dr. Betz's records review report specifies the medical evidence confirming Claimant had a preexisting condition:

> Dr. Anderson correctly points out that the patient's cervical pathologies were primarily degenerative in nature and preexisting. This conclusion is further supported by Dr. Hall's opinion on March 16, 2016, in which he noted Ms. Kline's cervical symptoms were initially consistent with a sprain strain and that she recovered completely from the industrial injury with conservative treatments by the end of October 2015. He goes on to conclude that there is no objective evidence to connect the patient's significant MRI findings of January 13, 2016 with the

> industrial injury. It is also informative that Ms. Kline had no symptoms or examination findings of neck injury at time of her initial presentation to the ER and was not found to have acute injury related pathologies on MRI.
>
> If the occupational incident had significantly aggravated the patient's preexisting pathologies, the development of radiculopathy symptoms and findings would be expected in the first few days or weeks and not 5 months later. Consequently, it is likely that the patient's radicular symptoms were the result of a natural progression of her significant multilevel degenerative changes rather than the [industrial] injury.

(Ex. G at p. 5.)

Dr. Betz's record review also confirms that Claimant had a non-industrial car accident several months prior to the car accident that is subject to this industrial injury. (Ex. G at p. 1.) An MRI taken a month prior to the industrial injury confirmed the herniated disc at L3-4 and L4-5 had nearly resolved in the intervening period. (Ex. G at p. 2.) Claimant's symptoms reported after her the June 25, 2015 second auto accident were complaining of neck, upper back and low back pain. (Ex. G at p. 2.) He also reported that Claimant's January 13, 2016 MRI scan of her cervical spine was remarkable for disc degeneration with large disc protrusions at C5-6 and C6-7. (*Id.*) Dr. Betz reported that Claimant's neurosurgical consultation with Dr. Sekhon indicated the Claimant had preexisting spondylosis C4 through C7 with cord compression C5-6 and C6-7, mobile spondylolisthesis at C4-5 and failed conservative therapy. (*Id.*) Further, the accident exacerbated her underlying stenosis. (*Id.*) Dr. Betz reviewed the April 21, 2017 x-rays showing "mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7." (Ex. G at p. 3.) An MRI on the same day showed moderate posterior disc osteophyte complex through C4 through C6 resulting in mass effect upon the ventral spine cord and moderate to severe central canal stenosis." (*Id.*)

Ultimately, Dr. Betz agreed with Dr. Anderson's findings of apportionment noting Dr. Anderson's conclusions "are well supported by the medical record, known pathologies, AMA guides and Nevada Administrative Code." (Ex. G at p. 5.) Based on Dr. Betz's assessment, on June 13, 2018 third-party administrator issued a determination offering the Claimant a 6% PPD

award consistent with Dr. Betz and Dr. Anderson's findings. The Claimant appealed this determination as well and it is also the subject of this appeal. (Ex. D, p. 10.)

A hearing was conducted before a Hearings Officer on July 12, 2018 addressing both the third-party administrator's May 24, 2018 and June 13, 2018 determinations. (Ex. D, p. 1.) The Hearing Officer found that no evidence has been presented to justify 75% apportionment and the Claimant is entitled to the 27% PPD award determined by Dr. Jempsa. (*Id.*) The Employer appealed this decision.

At the appeal hearing on May 1, 2019, witness testimony was provided by Claimant. Dr. Betz was found to be a qualified and admitted as an expert. Dr. Betz testified that Claimant had cervical pathologies were primarily degenerative in nature and preexisting including the Claimant's spondylitis and stenosis. Dr. Betz explained that Claimant's MRI revealed moderate posterior disc osteophyte complex through C4 through C6. He testified that osteophytes take years if not decades to develop. Dr. Betz opined that neither the first car accident several months before the industrial injury, nor the second car accident causing the industrial injury could have caused osteophytes which take years to develop. Dr. Betz further testified that if the car accident was the cause of Claimant's resulting conditions, as opposed to aggravation of a preexisting condition, the symptoms would have been immediate as to a gradual onset. Dr. Betz also testified as to each historical record, diagnosis, x-ray, and MRI that he relied upon to determine apportionment.

The Appeals Officer finds Dr. Betz to be a credible witness and his testimony is given great weight. Dr. Betz's testimony was uncontroverted at hearing and no opposing or contradicting expert witness testimony was provided.

Any finding of facts if appropriate shall be construed as conclusions of law, and any conclusions of law if appropriate shall be construed as findings of fact.

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CONCLUSIONS OF LAW

I. Employer's Appeal Regarding a Second PPD Evaluation Has Been Resolved.

Appeal No. 1802418-RKN involves the Employer's appeal of the January 16, 2018 Hearing Officer Decision regarding the December 5, 2017 determination letter awarding Claimant a 6% PPD award. In this decision, the Hearing Officer remanded the determination letter finding a medical question on apportionment and ordering that a second PPD evaluation be conducted pursuant to NRS 616C.330. (Ex. 2, p. 1.)

NRS 616C.330(3) provides:

> If 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, the hearing officer may order an independent medical examination, which must not involve treatment, and refer the employee to a physician or chiropractor of his or her choice who has demonstrated special competence to treat the particular medical condition of the employee, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. If the medical question concerns the rating of a permanent disability, the hearing officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected 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 injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any medical examination requested by the hearing officer.

The Employer argued that the applicable statute where a claimant wants a second PPD evaluation and disagrees with the first PPD evaluation is NRS 616C.100. This statute provides:

> 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.

The Employer appealed this decision and sought a stay, challenging the Hearing Officer's statement that he "finds a medical question regarding Dr. Anderson's 75% apportionment." The Claimant submitted no medical evidence in support of her appeal from the determination letter.

With no conflicting medical evidence to contradict the records reviewed and relied upon by Dr. Anderson or the findings in his PPD evaluation, the Employer argued it was improper to order a second PPD evaluation pursuant to NRS 616C.330(3) as no medical question was established by the Claimant. Rather, the Claimant simply disagreed with the percentage of disability as determined by the rating physician. NRS 616C.100 provides for exactly this scenario. "If the 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." NRS 616C.100(1) (emphasis added). A stay pending the appeal hearing was entered.

Subsequently, the stay was lifted by the Appeals Officer. Pursuant to an order dated March 27, 2018, the Employer was ordered to schedule a second PPD evaluation. (Order, 3/27/18, Appeal No. 1802418-RKN.) Dr. Jempsa was chosen off the rotation list. (*See* Ex. 3, p. 1.) On May 8, 2018, Dr. Jempsa performed his PPD evaluation. (Ex. G at pp. 2-13.) His PPD evaluation report was issued on May 14, 2018. (*Id.*) With this second PPD evaluation having been ordered by the Appeals Officer, the issue on appeal in Appeal No. 1802418-RKN has been rendered moot. The Appeals Officer concludes that this appeal has been resolved by interim order requiring the Employer to schedule and pay for a second PPD evaluation with Dr. Jempsa. Therefore, there are no additional issues for this appeal to be resolved at hearing and the appeal is rendered moot with the completion of the evaluation by Dr. Jempsa.

II. Claimant's Appeal Regarding the Award of The Undisputed 6% PPD Award has Been Resolved.

Appeal No. 1902049-RKN involves the Claimant's appeal of the December 27, 2018 Hearing Officer Decision affirming and remanding Employer's third-party administrator's September 20, 2018 determination letter offering the undisputed amount of the PPD award, 6%, in lump sum or installments and the remaining disputed amount of the PPD award, 21%, in installments pursuant to NRS 616C.380.

NRS 616C.380(1) provides, "[i]f a hearing officer, appeals officer or district court renders a decision on a claim for compensation and the insurer or employer appeals that decision, but is unable to obtain a stay of the decision: (a) Payment of that portion of an award for a permanent

partial disability which is contested must be made in installment payments until the claim reaches final resolution."

On January 24, 2019, following entry of the Hearing Officer Decision, the parties discussed the proper calculation of the lump sum and installment payments pursuant to NRS 616C.380. (Ex. F, p. 1.) The parties reached an agreement as to the calculation and a new determination letter was entered wherein Employer's third-party administrator was to initiate installment payments on the 27% due to Claimant's affirmation that she would not be electing a lump sum payment. (*Id.*) This determination letter resolved the issue presented by the December 27, 2018 Hearing Officer Decision and underlying determination letter. Claimant did not appeal the January 24, 2019 determination letter reflecting the parties' agreement on payment of installments pending litigation pursuant to NRS 616C.380. As such, the Appeals Officer concludes that Appeal No. 1902049-RKN is rendered moot by the subsequent determination letter dated January 24, 2019. With no appeal having been filed, a final determination has been entered and Employer, through its third-party administrator, properly commencing payment of the 27% PPD award in dispute upon Claimant's election to not seek a lump sum payment, this payment is proper and consistent with NRS 616C.380.

III. The Claim Was Properly Closed With a 6% PPD Award and Apportionment.

Appeal No. 1900471-RKN is the Employer's appeal of the Hearing Officer Decision dated July 19, 2018, reversing its third-party administrators May 24, 2018 and June 13, 2018 determination letters. (Ex. D, p.1.) The May 24, 2018 determination letter notified Claimant that Dr. Jempsa's PPD evaluation with a 27% WPI was being held in abeyance. (Ex. D, p. 9.) The June 13, 2018 determination letter notified Claimant that Dr. Betz, in his records review report, agreed with Dr. Anderson that PPD should be apportioned and offered the 6% PPD award. (Ex. D, p. 10.) The disputed Hearing Officer Decision reversed these two determinations finding no medical evidence to justify 75% apportionment.

A. <u>The Medical Evidence Established a Preexisting Condition.</u>

NAC 616C.490 provides regarding apportionment:

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> 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.

Emphasis added.

Here, the medical evidence establishes that the Claimant had a preexisting condition which mandates the rating physician to apportion under NAC 616C.490(1). As identified by Dr. Anderson and Dr. Betz, the medical reporting in this case reflects the Claimant's history of preexisting cervical problems including the January 13, 2016 MRI and radiographic reports showing cervical spine degenerative discs with large protrusions at C5-6, C6-7, effacement of the CSF, and severe stenosis. (Ex. 1, p. 41.) Dr. Betz confirms that Dr. Anderson correctly points out that the "patient's cervical pathologies were primarily degenerative in nature and preexisting. This conclusion is further supported by Dr. Hall's opinion on March 16, 2016, in which he noted Ms. Kline's cervical symptoms were initially consistent with a sprain strain and that she recovered completely from the industrial injury with conservative treatments by the end of October 2015. He goes on to conclude that there is no objective evidence to connect the patient's significant MRI findings of January 13, 2016 with the industrial injury. It is also informative that Ms. Kline had no symptoms or examination findings of neck injury at time of her initial presentation to the ER and was not found to have acute injury related pathologies on MRI." (Ex. G at p. 5.)

Dr. Betz also opined that '[i]f the occupational incident had significantly aggravated the patient's preexisting pathologies, the development of radiculopathy symptoms and findings would be expected in the first few days or weeks and not 5 months later. Consequently, it is likely that the patient's radicular symptoms were the result of a natural progression of her significant multilevel degenerative changes rather than the [industrial] injury." (Ex. G at p. 5.)

Additionally, Dr. Betz reported that there is "no objective evidence to connect the significant MRI findings of January 13, 2016 with the industrial injury." (Ex. I, p. 181.) He indicates that "[r]epeat x-rays on April 21, 2017 show mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7." He also notes the Claimant showed improvement and physical therapy was recommended. Dr. Betz reported that Claimant's neurosurgical consultation with Dr. Sekhon indicated the Claimant had preexisting spondylosis C4 through C7 with cord compression C5-6 and C6-7, mobile spondylolisthesis at C4-5 and failed conservative therapy. (*Id.*) Further, the accident exacerbated her underlying stenosis. (*Id.*) Dr. Betz reviewed the April 21, 2017 x-rays showing "mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7." (Ex. G at p. 3.) An MRI on the same day showed moderate posterior disc osteophyte complex through C4 through C6 resulting in mass effect upon the ventral spine cord and moderate to severe central canal stenosis." (*Id.*)

Dr. Betz's record review also confirms that Claimant had a non-industrial car accident several months prior to the car accident that is subject to this industrial injury. (Ex. G, p. 1.) An MRI taken a month prior to the industrial injury confirmed the herniated disc at L3-4 and L4-5 had nearly resolved in the intervening period. (Ex. G, p. 2.) Claimant's symptoms reported after her the June 25, 2015 second auto accident were complaining of neck, upper back and low back pain. (Ex. G, p. 2.)

Dr. Betz testified as an expert at the hearing and further expanded upon his medical opinion. He explained that if the occupational incident had significantly aggravated the patient's

preexisting pathologies the development of radiculopathy symptoms and findings would be expected in the first few days or weeks, not five months later. Dr. Betz concludes that the Claimant's need for surgery was primarily the result of preexisting pathologies. Absent those preexisting pathologies the patient would not have been a candidate for multilevel cervical discectomy and fusion. It is the fusion that now forms the basis for the patient's substantial permanent partial impairment. He testified that the level of fusion had by Claimant is the most common performed for degenerative conditions. He also testified that a neck fusion is not done for a cervical strain but rather only for significant cervical issues.

Dr. Betz further testified that Claimant's April 21, 2017 MRI revealed osteophytes. He explained that osteophytes take years if not decades to develop. Therefore, this condition was not caused by either car accident but rather is a preexisting condition that developed over time.

Dr. Betz confirmed in his report and in his testimony that he reviewed all medical reporting including Dr. Men-Muir's reporting from June 25, 2015, Dr. Hall's reporting from June 30, 2015 and reporting releasing Claimant on October 30, 2015. He testified he reviewed the January 13, 2016 MRI which showed remarkable disc degeneration with large disc protrusions at C5-6 and C6-7. He testified that Claimant had advanced degenerative spondylosis at multiple levels and underlying stenosis. He testified that he reviewed Dr. Sekhon's reporting including the July 5, 2016 report addressing Claimant's preexisting spondylosis at C4 through C7 and underlying stenosis.

Dr. Betz testified that he reviewed the April 21, 2017 repeat MRI and x-rays which revealed moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis. He further reviewed the reporting from Dr. Sekhon's June 12, 2017 surgical report for the anterior cervical decompression C4 through C7 followed by interbody fusion.

Based on the medical reporting of Dr. Betz and Dr. Anderson, along with the expert testimony of Dr. Betz, the Appeals Officer concludes that the medical evidence establish Claimant

had a preexisting condition. Dr. Betz and Dr. Anderson are found to be credible and their opinions given the most weight.

No expert testimony was provided at hearing to contradict Dr. Betz. Further, while Claimant relies on Dr. Jempsa's reporting, the reporting is flawed. Dr. Jempsa reports that there are no prior records or ratings of the Claimant establishing a preexisting condition. As explained by Dr. Betz, this opinion is misplaced. Prior records or ratings are not necessary to establish a preexisting condition. He identified that page 2 of Chapter 1 of the AMA Guides, Fifth Edition, defines "impairment" as the loss of use or derangement of body part. There is no requirement that there be a "ratable impairment". NAC 616C.490 further confirms it is impairment, not ratable impairment, that is evaluated. In addition, the case *Ransier v. SIIS*, 104 Nev. 742, 744, 766 P. 2d 274, 275 (1988) also confirms it is appropriate to use medical records arising after the industrial injury to establish a preexisting condition when no records prior to the injury exist. *Id.* (finding that although no documents existed concerning Ransier's prior injury, both treating physicians found Ransier's two injuries to be distinguishable with a twisted knee differing greatly from osteoarthritic degeneration; competent evidence supported the physician's decision to apportion the two injuries). For this reason, Dr. Jempsa's PPD evaluation and addendum are flawed. Dr. Jempsa is not credible. He failed to consider the medical evidence establishing a preexisting condition.

Thus, based on all the medical evidence presented, and additionally the medical evidence reviewed and identified by Dr. Betz and Dr. Anderson establishing a preexisting condition, the Appeals Officer concludes that apportionment was required in this case pursuant to NAC 616C.490(1). NAC 616C.490(1) mandated that the rating physician "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." NAC 616C.490(2) requires that "the rating of a permanent partial disability must be apportioned if there is a preexisting permanent impairment or intervening injury." Claimant was

no entitled to compensation for the portion of impairment "which is reasonably attributable to the preexisting or intervening injury, disease or condition." NAC 616C.490(1).

B. <u>It was Proper to Determine Apportionment Based on the Medical Records.</u>

NAC 616C.490(5)-(6) provides:

> 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.

As detailed in the above subsection, both Dr. Anderson and Dr. Betz in the medical reporting, and Dr. Betz in his expert testimony, identified the x-rays, MRIs, historical records and diagnoses which established a prior impairment. This documentation supported the scope and nature of the impairments identified to be preexisting. Dr. Betz explained that medical records he reviewed showed that when Claimant initially treated with Dr. Hall, she complained of neck issues that resolved. Months later, she had new radiculopathy indicating a nerve root deficit. The new symptoms were consistent with compressed root nerves, disc osteophyte complex, and the combined pathologies with discs and growths compressed the spinal cord causing stenosis or narrowing. The fusion performed by Dr. Sekhon removed the osteophytes and fused the disc space, this addressed Claimant's pain by relieving pressure on the nerves.

At the hearing, in addition to identifying all medical records, MRIs, x-rays, historical records and diagnoses relied upon, relied upon, Dr. Betz testified as to how this medical documentation concerned the scope and nature of the impairment that existed before the industrial injury. Dr. Betz identified that the nature of the impairment is advanced degenerative spondylosis

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at multiple levels, stenosis, and osteophytes. This is reflected MRI and x-ray dated April 21, 2017 and further in Dr. Sekhon's July 5, 2016 medical reporting. He explained the scope was based on the medical reporting was severe, multi-level, and involved neurological compromise. He concluded that the present impairment was due at least 50% to Claimant's preexisting impairment.

As such, the Appeals Officer concludes that Dr. Anderson and Dr. Betz in their medical reporting, and Dr. Betz in his expert testimony, established under NAC 616C.490(5) that at least 50% of the Claimant's impairment was due to the preexisting condition. Dr. Anderson and Dr. Betz further established that apportionment for the impairment is supported the medical documentation concerning the nature and scope of the impairment as required by NAC 616C.490(6). These medial opinions and the expert testimony are found credible and satisfy the requirements under NAC 616C.490(5)-(6) for appointment. Both physicians further explained the underlying basis for the apportionment by citing pertinent data and medical records in support of their apportionment analysis. Dr. Betz provided detailed expert testimony as to each record relied upon and how that contributed to his apportionment analysis. For these reasons, NAC 616C.490(7) has also been satisfied by the medical evidence and expert testimony of Dr. Betz. Finally, Dr. Betz provided credible expert testimony confirming that his apportionment analysis also satisfied the requirements of the AMA Guides at page 11. Dr. Betz verified there was documentation of the prior factor, that the current impairment is greater as a result of the prior factor, and that there is evidence indicating the prior factor causes or contributed to the present impairment based on a reasonable probability.

The Appeals Officer further concludes that Dr. Anderson and Dr. Betz correctly relied on the medical evidence to determine that apportionment was required in this claim. Claimant's argument that there was an obligation for these physicians to consider prior legal decisions or legal determinations made by the Appeals Officer for this Claimant, and to ignore certain medical evidence as part of their apportionment analysis, is unsupported by, and contrary to, NAC 616C.490. Dr. Anderson and Dr. Betz properly looked to the medical evidence as required by NAC 616C.490(5)-(6) to determine apportionment was necessary in this case.

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The Appeals Officer concludes that Dr. Anderson's apportionment of the Claimant's present impairment as 75% non-industrial and 25% industrial was proper and credible. Dr. Betz in his medical records review, and in his expert testimony, likewise confirmed he agreed with Dr. Anderson's apportionment of the impairment as 75% non-industrial and 25% industrial. Dr. Betz's testimony was uncontroverted, credible and reliable.

Finally, Dr. Jempsa's PPD evaluation is given no weight and is found to be erroneous for multiple reasons. First, as identified by Dr. Betz, Dr. Anderson's and Dr. Jempsa's PPD evaluations both utilized a range of motion method and both agreed there is a 12% whole person impairment utilizing Table 15-7 and both conclude there was 1% whole person impairment for sensory deficit in the left C6 distribution. However, the large discrepancy exists on range of motion findings of Dr. Anderson of 7% versus that of Dr. Jempsa of 16%. Dr. Betz testified that the AMA Guides (which must be followed in a PPD evaluation pursuant to NRS 616C.490) dictate in this situation. He states that at page 399 of the Guides, "'the physician should seek consistency when testing active motion . . .Tests with inconsistent results should be repeated. Results that remain inconsistent should be disregarded." He goes on to explain that a physician must recognize findings can be subjective under the influence of the individual and that "[i]t is well recognized that patients learn from prior rating experience" and that this can have a great effect on findings the individual can control such as range of motion testing. This calls question to the findings by Dr. Jempsa.

Dr. Betz also identifies that Dr. Jempsa's evaluation is questionable due to the failure to address apportionment. He notes that Dr. Anderson "correctly points out that the patient's cervical pathologies were primarily degenerative in nature and preexisting." This is supported by the Claimant's complete recovery from the industrial injury. "If the occupational incident had significantly aggravated the patient's preexisting pathologies the development of radiculopathy symptoms and findings would be expected in the first few days or weeks, not 5 months later." Dr. Betz concludes that the Claimant's need for surgery "was primarily the result of preexisting pathologies. Absent those preexisting pathologies the patient would not have been a candidate for

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multilevel cervical discectomy and fusion. It is the fusion that now forms the basis for the patient's substantial permanent partial impairment."

Dr. Jempsa in his addendum stated that he did not apportion because the "claimant stated that she had no problems with her neck prior to her industrial injury on June 25, 2015. I have not received any medical records prior to the industrial injury of June 25, 2015." (Ex. I, p. 164.) As identified by Dr. Betz, the AMA Guides have no limitation that the medical records must pre-date the industrial injury or that an impairment rating have occurred. Rather, a physician must simply look for impairment and this can be evidenced in records post-dating the industrial injury. This is consistent with NAC 616C.490 which likewise looks to "impairment" based on the medical records with no requirement for a rating or for the records to pre-date the industrial injury. *Ransier* confirms apportionment is proper for a prior injury even when no prior rating or documents on the preexisting condition. *Ransier*, 104 Nev. at 744, 766 P.2d at 275. As detailed in Dr. Anderson's and Dr. Betz's reports, and Dr. Betz's testimony, the medical evidence depicts stenosis, spondylitis, and osteophytes which take years if not decades to form. These preexisting conditions were identified in the medical reporting. Dr. Jempsa's PPD evaluation and addendum are found not credible and contrary to the medical evidence and applicable law on apportionment. Dr. Jempsa's PPD rating of 27% is inconsistent with the medical reporting and fails to apportion as mandated by NAC 616C.490.

The Appeals Officer concludes that Dr. Anderson's and Dr. Betz's apportionment of the 25% whole person impairment as 75% non-industrial and 25% industrial is proper. The Claimant is entitled to a 6% PPD award after apportionment. The claim properly closed as of the date of Dr. Jempsa's PPD evaluation on May 8, 2018. Claimant is entitled to no additional benefits, medical treatment or compensation. Both the May 24, 2018 and June 13, 2018 determination letters are proper and affirmed. The July 19, 2018 Hearing Officer Decision is reversed.

IV. Apportionment is Required Under the Law of the Case

In a prior decision, Appeal No. 56832-RKN, the Appeals Officer determined the industrial injury aggravated a preexisting condition applying NRS 616C.175(1). The fact that the prior

decision concluded there was an aggravation of a preexisting condition does not preclude apportionment in a PPD evaluation of an impairment related to a preexisting condition. In fact, NRS 616C.490 and NAC 616C.490 apportionment of impairment related to a preexisting condition. Dr. Betz credibly testified that the industrial injury could not be the sole cause of Claimant's present impairment. Rather, Claimant that preexisting conditions and degenerative conditions that also contributed to Claimant's present impairment. Therefore, the Appeals Officer concludes that this decision is consistent with the law of the case set forth in the prior decision and that there must be apportionment in the PPD evaluation.

V. Claimant Shall Pay For Her Portion of the Expert Fees Incurred at Hearing

Prior to the appeal hearing, Claimant noticed the deposition of Dr. Betz. That deposition was continued multiple times by Claimant. The Claimant contended that the delay was due to the written discovery received by the Employer regarding their use of Dr. Betz as an expert. Ultimately, Claimant elected to question Dr. Betz at the time of hearing. The parties were each given equal time to examine and cross-examine Dr. Betz. Claimant elected to exceed her allotted time on cross-examination of Dr. Betz and agreed to pay for half of his fees incurred over the allotted time. The parties were ordered to share a half hour of Dr. Betz's time. Dr. Betz's rate for testimony is $750/hour. Therefore, Claimant's half of an half hour of time is $187.50. Claimant is hereby ordered to reimburse Employer's third-party administrator, CCSMI, within ten (10) days of entry of this order, for expert fees paid to Dr. Betz in the amount of $187.50.

DECISION

As to Appeal No. 1900471-RKN, the Hearing Officer Decision dated July 19, 2018 is hereby REVERSED. The underlying determinations dated May 24, 2018 and June 13, 2018 are AFFIRMED. Employer's third-party administrator properly offered Claimant a 6% PPD award following apportionment of the 25% PPD award as 75% non-industrial and 25% industrial, based on Dr. Anderson's PPD evaluation and Dr. Betz's records review report.

As to Appeal No. 1902049-RKN, this appeal is found to be resolved and the issue deemed moot pursuant to the parties' agreement as to payment of the installment payments pursuant to NRS 616C.380. The determination letter dated January 24, 2019 reflecting the parties' agreement was not appealed and is considered a final determination resolving the issue on appeal.

As to Appeal No. 1802418-RKN, the appeal is found to be resolved and the issue deemed moot pursuant to the Appeals Officer's Order Lifting the Stay and directing a second PPD evaluation. The completion of the second PPD evaluation by Dr. Jempsa resolved the issue on appeal rendering the appeal moot.

The claim was properly closed as of the May 8, 2018 date of Dr. Jempsa's PPD evaluation. Claimant was properly awarded a 6% PPD award, following apportionment of the 25% PPD award by Dr. Anderson, and as affirmed by Dr. Betz, which apportioned the whole person impairment as 75% non-industrial and 25% industrial. The Claimant may elect to accept her 6% PPD award in lump sum as awarded in the affirmed June 13, 2018, if she desires. Installment payments made since the date of offer can be properly deducted. The Insurer shall issue a lump sum offer with an updated calculation setting forth such deductions for installments paid.

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Claimant shall pay to Employer, through payment to third-party administrator, within ten days from the date of this order, the amount of $187.50 for expert fees incurred on behalf of Claimant at the appeal hearing.

DATED this 19th of August, 2019

Raymond Rau-Dress

APPEALS OFFICER

Submitted by:
LISA WILTSHIRE ALSTEAD
MCDONALD CARANO LLP

100 West Liberty St., 10th Floor
Reno, Nevada 89501

Notice: Pursuant to NRS 233B.130 should any party desire to appeal this final decision of the Appeals Officer, a Petition for Judicial Review must be filed with the district court within thirty (30) days after service by mail of this Decision.

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing ORDER was deposited into the State of Nevada Interdepartmental mail system, **OR** with the State of Nevada mail system for mailing via United States Postal Service, **OR** placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 1050 E. Williams Street, Suite 450, Carson City, Nevada, 89701 to the following:

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100 W LIBERTY ST 10TH FLOOR
RENO NV 89501

Dated this 21st day of August, 2019.

Brandy Fuller

Brandy Fuller, Legal Secretary II
Employee of the State of Nevada

CASE NO. CV19-01683

DEPT NO. 4

IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

* * * * *

KIMBERLY KLINE,

Petitioner,

vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES,"CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO, ESQ., Sr. Appeals Officer, ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

_____/

RECORD ON APPEAL

ORIGINAL

RECORD ON APPEAL

IN ACCORDANCE WITH THE

NEVADA ADMINISTRATIVE PROCEDURE ACT
(Chapter 233B of NRS)

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Attorney for Respondents

CASE NO. CV19-01683

DEPT NO. 4

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IN AND FOR THE COUNTY OF WASHOE

* * * * *

KIMBERLY KLINE,

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vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES,"CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO, ESQ., Sr. Appeals Officer, ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

_____/

AFFIRMATION
Pursuant to NRS 239B.030

The undersigned does hereby affirm that the following document **DOES NOT** contain the social security number of any person:

1. Record on Appeal

APPEALS OFFICER

RAJINDER K. RAI-NIELSEN, ESQ.

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September 18, 2019

HERBERT SANTOS, JR. ESQ.
225 S ARLINGTON AVE STE C
RENO NV 89501

Re: Kimberly Kline
Appeal: 1902049-RKN
In The Second Judicial District Court
Case No. CV19-01683, Dept. No. 4

Dear Mr. Santos:

Please be advised that on this date, the entire record on appeal, in the above-referenced claim was transmitted in accordance with the Nevada Administrative Procedure Act to the Clerk of the Second Judicial District Court of the State of Nevada, in and for the County of Washoe.

For your convenience, I have enclosed a photocopy of the index to the transmitted record.

Sincerely,
Brandy Fuller
Brandy Fuller,
Secretary to Appeals Officer

bf
Enclosure
cc: Lisa Wiltshire Alstead, Esq.

AA 0202

CASE NO. CV19-01683
DEPT. NO. 4

KIMBERLY KLINE VS. CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO, ESQ., Sr. Appeals Officer, ATTORNEY GENERAL AARON FORD, ESQ.

INDEX

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
APPEALS DIVISION

In the Matter of the Contested Industrial Insurance Claim of:

KIMBERLY KLINE,

Claimant.

Claim No.: 15853E839641

Hearing Nos.: 1803718-JL
1803717-JL
1901522-JL

Appeal Nos. 1900471-RKN
1902049-RKN
1802418-RKN

APPEALS OFFICER DECISION

An appeal hearing was conducted on May 1, 2019. Claimant Kimberly Kline ("Claimant") was represented by Herb Santos, Jr. of the Law Firm of Herb Santos, Jr. The self-insured employer City of Reno ("Employer") was represented by Lisa Wiltshire Alstead of the law firm McDonald Carano, LLP. The hearing was conducted pursuant to Chapters 616A through 617 and 233B of the Nevada Revised Statutes.

The issues presented in this appeal include:

1. **AO1900471-RKN** – The Employer's appeal of the July 19, 2018 Hearing Officer Decision reversing the Employer's third-party administrator's May 24, 2018 and June 13, 2018 determination letters. The May 24, 2018 determination letter notified Claimant that Dr. Jempsa's permanent partial disability ("PPD") rating of 27% was being held in abeyance. The June 13, 2018 determination letter offered Claimant a 6% PPD award based on Dr. Betz's reporting agreeing with Dr. Anderson's reporting as to appointment and offering a 6% PPD award. The Hearing Officer Decision reversed these decisions finding no medical evidence to justify a 75% apportionment.

2. **AO1902049-RKN** – Claimant's appeal of the December 27, 2018 Hearing Officer Decision affirming and remanding Employer's third-party administrator's September 20,

2018 determination letter offering the undisputed 6% PPD award in lump sum or installments and 21% in monthly installments pursuant to NRS 616C.380.

3. **AO1802418-RKN** – The Employer's appeal of the January 16, 2018 Hearing Officer Decision remanding the December 5, 2017 determination letter awarding a 6% PPD award. The Hearing Officer found a medical question on apportionment and ordering a second PPD evaluation under NRS 616C.330.

The evidence presented at hearing consisted of 14 separate multipage exhibits identified as Exhibits 1 through 4 (previously admitted in Appeal No. 1802418-RKN) and Exhibits A through J marked and entered into evidence at the time of hearing. Witness testimony was provided by Claimant. Jay Betz, M.D. was qualified as an expert and provided expert testimony. Having reviewed the documentary evidence submitted by the parties, considered the witness and expert testimony at the appeal hearing, and considered the arguments of counsel, the Appeals Officer makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

The Claimant worked as a parking enforcement officer for the City. On June 25, 2015, the Claimant was injured when her work vehicle was rear ended by another vehicle. (Ex. 2, pp. 4-6.) This was her second motor vehicle accident within a month, the first of which occurred on or around June 3, 2015. (Ex. 2, p. 16.) Claimant's prior injury from the first accident was nearly resolved at the time of the second injury. [1] (Ex .2, p. 16.)

The Claimant was treated at St. Mary's Regional Medical Center for back and neck pain. (Ex. 2, pp. 16-18.) She was diagnosed by Dr. Richard Law with an acute lumbar radiculopathy, sprain of the lumbar spine, and acute pain the lower back. (Ex. 2, p. 17.) On July 23, 2015, the claim was accepted for cervical strain. (Ex. 2, p. 60.) The Claimant received medical treatment with Scott Hall, M.D. in addition to chiropractic care and physical therapy. (*See generally* Ex. 2.)

[1] In AO 56832-RKN, this Court found that the Claimant's industrial claim was closed prematurely. (Ex. 1, pp. 161-170.)

On October 28, 2015, Dr. Hall found the Claimant's condition at maximum medical improvement, stable not ratable, and released her to full duty with no restrictions. (Ex. 2, p. 97.)

On January 13, 2016, the Claimant underwent an MRI, which found disc degeneration with large disc protrusions at the C5-C6 levels resulting in complete effacement of CSF from the ventral and dorsal aspects of the cord with severe canal stenosis. (Ex. 2, p. 110.) In AO 56832-RKN, this Court specifically found that Dr. Hansen specifically opined that the "MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision." (Ex. 1, p. 167.)

On March 16, 2016, Dr. Hall noted that there was no evidence of neurologic involvement after the June 25, 2015 accident, specifically stating that the new onset of severe symptoms started quite suddenly and it is uncertain if there is any relation to the industrial injury, also noting that the Claimant sought treatment from an orthopedist prior to the June 2015 injury. (Ex. 2, pp. 151-152.) Finally, Dr. Hall noted that all indications were that the Claimant had completely recovered from the industrial injury by the end of October, 2015. (*Id.*)

On July 5, 2016, the Claimant saw Lali Sekhon, M.D. who recommended a C4-C5 to C6-7 decompression and fusion surgery. (Ex. 1, pp. 78-83.) On June 12, 2017, Dr. Sekhon performed a C4-5, C5-6, and C6-7 anterior cervical decompression, interbody fusion. (Ex. I, p. 126.) On September 11, 2017, Dr. Sekhon determined that Claimant reached maximum medical improvement, released her to full duty, and she was ratable. (Ex. A, p. 148.)

On November 10, 2017, Dr. Russell Anderson conducted a PPD evaluation. (Ex. 2, pp. 165-171.) Dr. Anderson concluded that the Claimant has a 25% whole person impairment from the cervical spine. (*Id.* at 171.) Dr. Anderson's report further stated the Claimant had underlying cervical spine issues that pre-date this work-related car accident and injury, specifically addressing an MRI on January 3, 2016, and radiograph reports which show cervical spine degenerative discs with large protrusions at C5-6, C6-7, effacement of the CSF and severe canal stenosis. (*Id.*) Dr. Anderson stated, "It is not logical to believe that these findings are related to the car accident she

was involved in 6 months earlier." (*Id.* at 170.) Thus, 75% of the impairment was apportioned as non-industrial. (*Id.* at 180-171.)

The 25% of the Claimant's impairment that was apportioned as industrial was concluded as such because: (i) the Claimant had no documented cervical spine injury or pain immediately after the accident (symptoms began June 30, 2015), after that, the cervical strain could be described as slight; (ii) the findings of cervical spine spondylosis, stenosis, and disc bulges cannot be logically attributable to this car accident/ work injury. These findings provided the indication for fusion surgery in the cervical spine; and (iii) the Claimant had responded well to physical therapy and medical treatment and had nearly completely resolved her cervical spine complaints prior to December, 2015, and she had no upper extremity symptoms at the time of release from care. (*Id.* at 170.)

Finally, Dr. Anderson's report acknowledges that the Claimant denies any prior upper extremity symptoms before this injury, however, this work injury likely played some role in the onset of symptoms that led to surgery, but was not the primary cause. (*Id.*) Based on Dr. Anderson's review, 75% of the impairment was apportioned as non-industrial. (*Id.*) As such, he concluded that Claimant has a 6% whole person impairment related to the June 25, 2015 industrial injury. (*Id.*) Dr. Anderson is found to be credible and his reporting reliable.

On December 5, 2017, the third-party administrator issued a determination letter awarding a 6% PPD award based on Dr. Anderson's PPD evaluation. (Ex. 2, p. 175.) The Claimant appealed this determination and a hearing was conducted by the Hearing Officer on January 10, 2018. On January 16, 2018, the Hearing Officer entered a Decision and Order remanding the determination finding a medical question regarding Dr. Anderson's 75% apportionment and ordering a second PPD evaluation. The Employer appealed this determination and requested a stay.

A stay was initially entered. It was subsequently lifted and a second evaluation ordered. (Order, 3/27/18, Appeal No. 1802418-RKN.) James Jempsa, M.D. conducted the second PPD evaluation on May 8, 2018. (Ex. G, p. 13.) Dr. Jempsa found a 27% whole person impairment and failed to address apportionment. (Ex G, p. 13.) Because apportionment was not addressed,

the third-party administrator sent a follow up request that Dr. Jempsa review Dr. Anderson's PPD evaluation and address apportionment. (*See* Ex. G, p. 26.) On May 18, 2018, Dr. Jempsa provided an Addendum which stated, "You will need to contact Dr. Anderson concerning his rationale for apportionment. . . the Claimant stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. I have not received any medical records prior to the industrial injury. . . it is my opinion that apportionment is not necessary in this case." (*See id.*) Dr. Jempsa is found to not be credible and his report is not given any weight. Dr. Jempsa failed to consider Claimant's preexisting conditions as evidenced in the medical reporting.

Subsequently, the third-party administrator sought a records review by Jay Betz, M.D. On May 24, 2018, third-party administrator sent notice out to the Claimant that it is holding the PPD award in abeyance pending Dr. Betz's review. The Claimant appealed this determination and it is the subject of this appeal.

On June 4, 2018, Dr. Betz provided his review. (Ex. H, pp. 6.) Dr. Betz noted that both Dr. Anderson and Dr. Jempsa agreed there is 12% whole person impairment utilizing Table 15-7 and that there was a 1% whole person impairment for sensory deficit in the left C6 distribution. (Ex. G at p. 4.) However, there was a large discrepancy between the active range of motion findings. Dr. Betz continued on stating that Dr. Jempsa provided no discussion or explanation for the substantial variation, and it is well recognized that patients learn from prior rating experiences, particularly when findings are "under the influence of the individual," such as active range of motion. (Ex. G. at p. 4.) Dr. Betz states that, absent an objective basis for the variation, Dr. Anderson's range of motion findings should have priority. (Ex. G. at p. 5.)

Dr. Betz's records review report specifies the medical evidence confirming Claimant had a preexisting condition:

> Dr. Anderson correctly points out that the patient's cervical pathologies were primarily degenerative in nature and preexisting. This conclusion is further supported by Dr. Hall's opinion on March 16, 2016, in which he noted Ms. Kline's cervical symptoms were initially consistent with a sprain strain and that she recovered completely from the industrial injury with conservative treatments by the end of October 2015. He goes on to conclude that there is no objective evidence to connect the patient's significant MRI findings of January 13, 2016 with the

> industrial injury. It is also informative that Ms. Kline had no symptoms or examination findings of neck injury at time of her initial presentation to the ER and was not found to have acute injury related pathologies on MRI.
>
> If the occupational incident had significantly aggravated the patient's preexisting pathologies, the development of radiculopathy symptoms and findings would be expected in the first few days or weeks and not 5 months later. Consequently, it is likely that the patient's radicular symptoms were the result of a natural progression of her significant multilevel degenerative changes rather than the [industrial] injury.

(Ex. G at p. 5.)

Dr. Betz's record review also confirms that Claimant had a non-industrial car accident several months prior to the car accident that is subject to this industrial injury. (Ex. G at p. 1.) An MRI taken a month prior to the industrial injury confirmed the herniated disc at L3-4 and L4-5 had nearly resolved in the intervening period. (Ex. G at p. 2.) Claimant's symptoms reported after her the June 25, 2015 second auto accident were complaining of neck, upper back and low back pain. (Ex. G at p. 2.) He also reported that Claimant's January 13, 2016 MRI scan of her cervical spine was remarkable for disc degeneration with large disc protrusions at C5-6 and C6-7. (*Id.*) Dr. Betz reported that Claimant's neurosurgical consultation with Dr. Sekhon indicated the Claimant had preexisting spondylosis C4 through C7 with cord compression C5-6 and C6-7, mobile spondylolisthesis at C4-5 and failed conservative therapy. (*Id.*) Further, the accident exacerbated her underlying stenosis. (*Id.*) Dr. Betz reviewed the April 21, 2017 x-rays showing "mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7." (Ex. G at p. 3.) An MRI on the same day showed moderate posterior disc osteophyte complex through C4 through C6 resulting in mass effect upon the ventral spine cord and moderate to severe central canal stenosis." (*Id.*)

Ultimately, Dr. Betz agreed with Dr. Anderson's findings of apportionment noting Dr. Anderson's conclusions "are well supported by the medical record, known pathologies, AMA guides and Nevada Administrative Code." (Ex. G at p. 5.) Based on Dr. Betz's assessment, on June 13, 2018 third-party administrator issued a determination offering the Claimant a 6% PPD

award consistent with Dr. Betz and Dr. Anderson's findings. The Claimant appealed this determination as well and it is also the subject of this appeal. (Ex. D, p. 10.)

A hearing was conducted before a Hearings Officer on July 12, 2018 addressing both the third-party administrator's May 24, 2018 and June 13, 2018 determinations. (Ex. D, p. 1.) The Hearing Officer found that no evidence has been presented to justify 75% apportionment and the Claimant is entitled to the 27% PPD award determined by Dr. Jempsa. (*Id.*) The Employer appealed this decision.

At the appeal hearing on May 1, 2019, witness testimony was provided by Claimant. Dr. Betz was found to be a qualified and admitted as an expert. Dr. Betz testified that Claimant had cervical pathologies were primarily degenerative in nature and preexisting including the Claimant's spondylitis and stenosis. Dr. Betz explained that Claimant's MRI revealed moderate posterior disc osteophyte complex through C4 through C6. He testified that osteophytes take years if not decades to develop. Dr. Betz opined that neither the first car accident several months before the industrial injury, nor the second car accident causing the industrial injury could have caused osteophytes which take years to develop. Dr. Betz further testified that if the car accident was the cause of Claimant's resulting conditions, as opposed to aggravation of a preexisting condition, the symptoms would have been immediate as to a gradual onset. Dr. Betz also testified as to each historical record, diagnosis, x-ray, and MRI that he relied upon to determine apportionment.

The Appeals Officer finds Dr. Betz to be a credible witness and his testimony is given great weight. Dr. Betz's testimony was uncontroverted at hearing and no opposing or contradicting expert witness testimony was provided.

Any finding of facts if appropriate shall be construed as conclusions of law, and any conclusions of law if appropriate shall be construed as findings of fact.

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CONCLUSIONS OF LAW

I. Employer's Appeal Regarding a Second PPD Evaluation Has Been Resolved.

Appeal No. 1802418-RKN involves the Employer's appeal of the January 16, 2018 Hearing Officer Decision regarding the December 5, 2017 determination letter awarding Claimant a 6% PPD award. In this decision, the Hearing Officer remanded the determination letter finding a medical question on apportionment and ordering that a second PPD evaluation be conducted pursuant to NRS 616C.330. (Ex. 2, p. 1.)

NRS 616C.330(3) provides:

> If 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, the hearing officer may order an independent medical examination, which must not involve treatment, and refer the employee to a physician or chiropractor of his or her choice who has demonstrated special competence to treat the particular medical condition of the employee, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. If the medical question concerns the rating of a permanent disability, the hearing officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected 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 injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any medical examination requested by the hearing officer.

The Employer argued that the applicable statute where a claimant wants a second PPD evaluation and disagrees with the first PPD evaluation is NRS 616C.100. This statute provides:

> 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.

The Employer appealed this decision and sought a stay, challenging the Hearing Officer's statement that he "finds a medical question regarding Dr. Anderson's 75% apportionment." The Claimant submitted no medical evidence in support of her appeal from the determination letter.

With no conflicting medical evidence to contradict the records reviewed and relied upon by Dr. Anderson or the findings in his PPD evaluation, the Employer argued it was improper to order a second PPD evaluation pursuant to NRS 616C.330(3) as no medical question was established by the Claimant. Rather, the Claimant simply disagreed with the percentage of disability as determined by the rating physician. NRS 616C.100 provides for exactly this scenario. "If the 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." NRS 616C.100(1) (emphasis added). A stay pending the appeal hearing was entered.

Subsequently, the stay was lifted by the Appeals Officer. Pursuant to an order dated March 27, 2018, the Employer was ordered to schedule a second PPD evaluation. (Order, 3/27/18, Appeal No. 1802418-RKN.) Dr. Jempsa was chosen off the rotation list. (*See* Ex. 3, p. 1.) On May 8, 2018, Dr. Jempsa performed his PPD evaluation. (Ex. G at pp. 2-13.) His PPD evaluation report was issued on May 14, 2018. (*Id.*) With this second PPD evaluation having been ordered by the Appeals Officer, the issue on appeal in Appeal No. 1802418-RKN has been rendered moot. The Appeals Officer concludes that this appeal has been resolved by interim order requiring the Employer to schedule and pay for a second PPD evaluation with Dr. Jempsa. Therefore, there are no additional issues for this appeal to be resolved at hearing and the appeal is rendered moot with the completion of the evaluation by Dr. Jempsa.

II. Claimant's Appeal Regarding the Award of The Undisputed 6% PPD Award has Been Resolved.

Appeal No. 1902049-RKN involves the Claimant's appeal of the December 27, 2018 Hearing Officer Decision affirming and remanding Employer's third-party administrator's September 20, 2018 determination letter offering the undisputed amount of the PPD award, 6%, in lump sum or installments and the remaining disputed amount of the PPD award, 21%, in installments pursuant to NRS 616C.380.

NRS 616C.380(1) provides, "[i]f a hearing officer, appeals officer or district court renders a decision on a claim for compensation and the insurer or employer appeals that decision, but is unable to obtain a stay of the decision: (a) Payment of that portion of an award for a permanent

partial disability which is contested must be made in installment payments until the claim reaches final resolution."

On January 24, 2019, following entry of the Hearing Officer Decision, the parties discussed the proper calculation of the lump sum and installment payments pursuant to NRS 616C.380. (Ex. F, p. 1.) The parties reached an agreement as to the calculation and a new determination letter was entered wherein Employer's third-party administrator was to initiate installment payments on the 27% due to Claimant's affirmation that she would not be electing a lump sum payment. (*Id.*) This determination letter resolved the issue presented by the December 27, 2018 Hearing Officer Decision and underlying determination letter. Claimant did not appeal the January 24, 2019 determination letter reflecting the parties' agreement on payment of installments pending litigation pursuant to NRS 616C.380. As such, the Appeals Officer concludes that Appeal No. 1902049-RKN is rendered moot by the subsequent determination letter dated January 24, 2019. With no appeal having been filed, a final determination has been entered and Employer, through its third-party administrator, properly commencing payment of the 27% PPD award in dispute upon Claimant's election to not seek a lump sum payment, this payment is proper and consistent with NRS 616C.380.

III. The Claim Was Properly Closed With a 6% PPD Award and Apportionment.

Appeal No. 1900471-RKN is the Employer's appeal of the Hearing Officer Decision dated July 19, 2018, reversing its third-party administrators May 24, 2018 and June 13, 2018 determination letters. (Ex. D, p.1.) The May 24, 2018 determination letter notified Claimant that Dr. Jempsa's PPD evaluation with a 27% WPI was being held in abeyance. (Ex. D, p. 9.) The June 13, 2018 determination letter notified Claimant that Dr. Betz, in his records review report, agreed with Dr. Anderson that PPD should be apportioned and offered the 6% PPD award. (Ex. D, p. 10.) The disputed Hearing Officer Decision reversed these two determinations finding no medical evidence to justify 75% apportionment.

A. <u>The Medical Evidence Established a Preexisting Condition.</u>

NAC 616C.490 provides regarding apportionment:

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.

Emphasis added.

Here, the medical evidence establishes that the Claimant had a preexisting condition which mandates the rating physician to apportion under NAC 616C.490(1). As identified by Dr. Anderson and Dr. Betz, the medical reporting in this case reflects the Claimant's history of preexisting cervical problems including the January 13, 2016 MRI and radiographic reports showing cervical spine degenerative discs with large protrusions at C5-6, C6-7, effacement of the CSF, and severe stenosis. (Ex. 1, p. 41.) Dr. Betz confirms that Dr. Anderson correctly points out that the "patient's cervical pathologies were primarily degenerative in nature and preexisting. This conclusion is further supported by Dr. Hall's opinion on March 16, 2016, in which he noted Ms. Kline's cervical symptoms were initially consistent with a sprain strain and that she recovered completely from the industrial injury with conservative treatments by the end of October 2015. He goes on to conclude that there is no objective evidence to connect the patient's significant MRI findings of January 13, 2016 with the industrial injury. It is also informative that Ms. Kline had no symptoms or examination findings of neck injury at time of her initial presentation to the ER and was not found to have acute injury related pathologies on MRI." (Ex. G at p. 5.)

Dr. Betz also opined that '[i]f the occupational incident had significantly aggravated the patient's preexisting pathologies, the development of radiculopathy symptoms and findings would be expected in the first few days or weeks and not 5 months later. Consequently, it is likely that the patient's radicular symptoms were the result of a natural progression of her significant multilevel degenerative changes rather than the [industrial] injury." (Ex. G at p. 5.)

Additionally, Dr. Betz reported that there is "no objective evidence to connect the significant MRI findings of January 13, 2016 with the industrial injury." (Ex. I, p. 181.) He indicates that "[r]epeat x-rays on April 21, 2017 show mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7." He also notes the Claimant showed improvement and physical therapy was recommended. Dr. Betz reported that Claimant's neurosurgical consultation with Dr. Sekhon indicated the Claimant had preexisting spondylosis C4 through C7 with cord compression C5-6 and C6-7, mobile spondylolisthesis at C4-5 and failed conservative therapy. (*Id.*) Further, the accident exacerbated her underlying stenosis. (*Id.*) Dr. Betz reviewed the April 21, 2017 x-rays showing "mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7." (Ex. G at p. 3.) An MRI on the same day showed moderate posterior disc osteophyte complex through C4 through C6 resulting in mass effect upon the ventral spine cord and moderate to severe central canal stenosis." (*Id.*)

Dr. Betz's record review also confirms that Claimant had a non-industrial car accident several months prior to the car accident that is subject to this industrial injury. (Ex. G, p. 1.) An MRI taken a month prior to the industrial injury confirmed the herniated disc at L3-4 and L4-5 had nearly resolved in the intervening period. (Ex. G, p. 2.) Claimant's symptoms reported after her the June 25, 2015 second auto accident were complaining of neck, upper back and low back pain. (Ex. G, p. 2.)

Dr. Betz testified as an expert at the hearing and further expanded upon his medical opinion. He explained that if the occupational incident had significantly aggravated the patient's

preexisting pathologies the development of radiculopathy symptoms and findings would be expected in the first few days or weeks, not five months later. Dr. Betz concludes that the Claimant's need for surgery was primarily the result of preexisting pathologies. Absent those preexisting pathologies the patient would not have been a candidate for multilevel cervical discectomy and fusion. It is the fusion that now forms the basis for the patient's substantial permanent partial impairment. He testified that the level of fusion had by Claimant is the most common performed for degenerative conditions. He also testified that a neck fusion is not done for a cervical strain but rather only for significant cervical issues.

Dr. Betz further testified that Claimant's April 21, 2017 MRI revealed osteophytes. He explained that osteophytes take years if not decades to develop. Therefore, this condition was not caused by either car accident but rather is a preexisting condition that developed over time.

Dr. Betz confirmed in his report and in his testimony that he reviewed all medical reporting including Dr. Men-Muir's reporting from June 25, 2015, Dr. Hall's reporting from June 30, 2015 and reporting releasing Claimant on October 30, 2015. He testified he reviewed the January 13, 2016 MRI which showed remarkable disc degeneration with large disc protrusions at C5-6 and C6-7. He testified that Claimant had advanced degenerative spondylosis at multiple levels and underlying stenosis. He testified that he reviewed Dr. Sekhon's reporting including the July 5, 2016 report addressing Claimant's preexisting spondylosis at C4 through C7 and underlying stenosis.

Dr. Betz testified that he reviewed the April 21, 2017 repeat MRI and x-rays which revealed moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis. He further reviewed the reporting from Dr. Sekhon's June 12, 2017 surgical report for the anterior cervical decompression C4 through C7 followed by interbody fusion.

Based on the medical reporting of Dr. Betz and Dr. Anderson, along with the expert testimony of Dr. Betz, the Appeals Officer concludes that the medical evidence establish Claimant

had a preexisting condition. Dr. Betz and Dr. Anderson are found to be credible and their opinions given the most weight.

No expert testimony was provided at hearing to contradict Dr. Betz. Further, while Claimant relies on Dr. Jempsa's reporting, the reporting is flawed. Dr. Jempsa reports that there are no prior records or ratings of the Claimant establishing a preexisting condition. As explained by Dr. Betz, this opinion is misplaced. Prior records or ratings are not necessary to establish a preexisting condition. He identified that page 2 of Chapter 1 of the AMA Guides, Fifth Edition, defines "impairment" as the loss of use or derangement of body part. There is no requirement that there be a "ratable impairment". NAC 616C.490 further confirms it is impairment, not ratable impairment, that is evaluated. In addition, the case *Ransier v. SIIS*, 104 Nev. 742, 744, 766 P. 2d 274, 275 (1988) also confirms it is appropriate to use medical records arising after the industrial injury to establish a preexisting condition when no records prior to the injury exist. *Id.* (finding that although no documents existed concerning Ransier's prior injury, both treating physicians found Ransier's two injuries to be distinguishable with a twisted knee differing greatly from osteoarthritic degeneration; competent evidence supported the physician's decision to apportion the two injuries). For this reason, Dr. Jempsa's PPD evaluation and addendum are flawed. Dr. Jempsa is not credible. He failed to consider the medical evidence establishing a preexisting condition.

Thus, based on all the medical evidence presented, and additionally the medical evidence reviewed and identified by Dr. Betz and Dr. Anderson establishing a preexisting condition, the Appeals Officer concludes that apportionment was required in this case pursuant to NAC 616C.490(1). NAC 616C.490(1) mandated that the rating physician "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." NAC 616C.490(2) requires that "the rating of a permanent partial disability must be apportioned if there is a preexisting permanent impairment or intervening injury." Claimant was

no entitled to compensation for the portion of impairment "which is reasonably attributable to the preexisting or intervening injury, disease or condition." NAC 616C.490(1).

B. <u>It was Proper to Determine Apportionment Based on the Medical Records.</u>

NAC 616C.490(5)-(6) provides:

> 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.

As detailed in the above subsection, both Dr. Anderson and Dr. Betz in the medical reporting, and Dr. Betz in his expert testimony, identified the x-rays, MRIs, historical records and diagnoses which established a prior impairment. This documentation supported the scope and nature of the impairments identified to be preexisting. Dr. Betz explained that medical records he reviewed showed that when Claimant initially treated with Dr. Hall, she complained of neck issues that resolved. Months later, she had new radiculopathy indicating a nerve root deficit. The new symptoms were consistent with compressed root nerves, disc osteophyte complex, and the combined pathologies with discs and growths compressed the spinal cord causing stenosis or narrowing. The fusion performed by Dr. Sekhon removed the osteophytes and fused the disc space, this addressed Claimant's pain by relieving pressure on the nerves.

At the hearing, in addition to identifying all medical records, MRIs, x-rays, historical records and diagnoses relied upon, relied upon, Dr. Betz testified as to how this medical documentation concerned the scope and nature of the impairment that existed before the industrial injury. Dr. Betz identified that the nature of the impairment is advanced degenerative spondylosis

at multiple levels, stenosis, and osteophytes. This is reflected MRI and x-ray dated April 21, 2017 and further in Dr. Sekhon's July 5, 2016 medical reporting. He explained the scope was based on the medical reporting was severe, multi-level, and involved neurological compromise. He concluded that the present impairment was due at least 50% to Claimant's preexisting impairment.

As such, the Appeals Officer concludes that Dr. Anderson and Dr. Betz in their medical reporting, and Dr. Betz in his expert testimony, established under NAC 616C.490(5) that at least 50% of the Claimant's impairment was due to the preexisting condition. Dr. Anderson and Dr. Betz further established that apportionment for the impairment is supported the medical documentation concerning the nature and scope of the impairment as required by NAC 616C.490(6). These medial opinions and the expert testimony are found credible and satisfy the requirements under NAC 616C.490(5)-(6) for appointment. Both physicians further explained the underlying basis for the apportionment by citing pertinent data and medical records in support of their apportionment analysis. Dr. Betz provided detailed expert testimony as to each record relied upon and how that contributed to his apportionment analysis. For these reasons, NAC 616C.490(7) has also been satisfied by the medical evidence and expert testimony of Dr. Betz. Finally, Dr. Betz provided credible expert testimony confirming that his apportionment analysis also satisfied the requirements of the AMA Guides at page 11. Dr. Betz verified there was documentation of the prior factor, that the current impairment is greater as a result of the prior factor, and that there is evidence indicating the prior factor causes or contributed to the present impairment based on a reasonable probability.

The Appeals Officer further concludes that Dr. Anderson and Dr. Betz correctly relied on the medical evidence to determine that apportionment was required in this claim. Claimant's argument that there was an obligation for these physicians to consider prior legal decisions or legal determinations made by the Appeals Officer for this Claimant, and to ignore certain medical evidence as part of their apportionment analysis, is unsupported by, and contrary to, NAC 616C.490. Dr. Anderson and Dr. Betz properly looked to the medical evidence as required by NAC 616C.490(5)-(6) to determine apportionment was necessary in this case.

The Appeals Officer concludes that Dr. Anderson's apportionment of the Claimant's present impairment as 75% non-industrial and 25% industrial was proper and credible. Dr. Betz in his medical records review, and in his expert testimony, likewise confirmed he agreed with Dr. Anderson's apportionment of the impairment as 75% non-industrial and 25% industrial. Dr. Betz's testimony was uncontroverted, credible and reliable.

Finally, Dr. Jempsa's PPD evaluation is given no weight and is found to be erroneous for multiple reasons. First, as identified by Dr. Betz, Dr. Anderson's and Dr. Jempsa's PPD evaluations both utilized a range of motion method and both agreed there is a 12% whole person impairment utilizing Table 15-7 and both conclude there was 1% whole person impairment for sensory deficit in the left C6 distribution. However, the large discrepancy exists on range of motion findings of Dr. Anderson of 7% versus that of Dr. Jempsa of 16%. Dr. Betz testified that the AMA Guides (which must be followed in a PPD evaluation pursuant to NRS 616C.490) dictate in this situation. He states that at page 399 of the Guides, "'the physician should seek consistency when testing active motion . . .Tests with inconsistent results should be repeated. Results that remain inconsistent should be disregarded." He goes on to explain that a physician must recognize findings can be subjective under the influence of the individual and that "[i]t is well recognized that patients learn from prior rating experience" and that this can have a great effect on findings the individual can control such as range of motion testing. This calls question to the findings by Dr. Jempsa.

Dr. Betz also identifies that Dr. Jempsa's evaluation is questionable due to the failure to address apportionment. He notes that Dr. Anderson "correctly points out that the patient's cervical pathologies were primarily degenerative in nature and preexisting." This is supported by the Claimant's complete recovery from the industrial injury. "If the occupational incident had significantly aggravated the patient's preexisting pathologies the development of radiculopathy symptoms and findings would be expected in the first few days or weeks, not 5 months later." Dr. Betz concludes that the Claimant's need for surgery "was primarily the result of preexisting pathologies. Absent those preexisting pathologies the patient would not have been a candidate for

multilevel cervical discectomy and fusion. It is the fusion that now forms the basis for the patient's substantial permanent partial impairment."

Dr. Jempsa in his addendum stated that he did not apportion because the "claimant stated that she had no problems with her neck prior to her industrial injury on June 25, 2015. I have not received any medical records prior to the industrial injury of June 25, 2015." (Ex. I, p. 164.) As identified by Dr. Betz, the AMA Guides have no limitation that the medical records must pre-date the industrial injury or that an impairment rating have occurred. Rather, a physician must simply look for impairment and this can be evidenced in records post-dating the industrial injury. This is consistent with NAC 616C.490 which likewise looks to "impairment" based on the medical records with no requirement for a rating or for the records to pre-date the industrial injury. *Ransier* confirms apportionment is proper for a prior injury even when no prior rating or documents on the preexisting condition. *Ransier*, 104 Nev. at 744, 766 P.2d at 275. As detailed in Dr. Anderson's and Dr. Betz's reports, and Dr. Betz's testimony, the medical evidence depicts stenosis, spondylitis, and osteophytes which take years if not decades to form. These preexisting conditions were identified in the medical reporting. Dr. Jempsa's PPD evaluation and addendum are found not credible and contrary to the medical evidence and applicable law on apportionment. Dr. Jempsa's PPD rating of 27% is inconsistent with the medical reporting and fails to apportion as mandated by NAC 616C.490.

The Appeals Officer concludes that Dr. Anderson's and Dr. Betz's apportionment of the 25% whole person impairment as 75% non-industrial and 25% industrial is proper. The Claimant is entitled to a 6% PPD award after apportionment. The claim properly closed as of the date of Dr. Jempsa's PPD evaluation on May 8, 2018. Claimant is entitled to no additional benefits, medical treatment or compensation. Both the May 24, 2018 and June 13, 2018 determination letters are proper and affirmed. The July 19, 2018 Hearing Officer Decision is reversed.

IV. Apportionment is Required Under the Law of the Case

In a prior decision, Appeal No. 56832-RKN, the Appeals Officer determined the industrial injury aggravated a preexisting condition applying NRS 616C.175(1). The fact that the prior

decision concluded there was an aggravation of a preexisting condition does not preclude apportionment in a PPD evaluation of an impairment related to a preexisting condition. In fact, NRS 616C.490 and NAC 616C.490 apportionment of impairment related to a preexisting condition. Dr. Betz credibly testified that the industrial injury could not be the sole cause of Claimant's present impairment. Rather, Claimant that preexisting conditions and degenerative conditions that also contributed to Claimant's present impairment. Therefore, the Appeals Officer concludes that this decision is consistent with the law of the case set forth in the prior decision and that there must be apportionment in the PPD evaluation.

V. Claimant Shall Pay For Her Portion of the Expert Fees Incurred at Hearing

Prior to the appeal hearing, Claimant noticed the deposition of Dr. Betz. That deposition was continued multiple times by Claimant. The Claimant contended that the delay was due to the written discovery received by the Employer regarding their use of Dr. Betz as an expert. Ultimately, Claimant elected to question Dr. Betz at the time of hearing. The parties were each given equal time to examine and cross-examine Dr. Betz. Claimant elected to exceed her allotted time on cross-examination of Dr. Betz and agreed to pay for half of his fees incurred over the allotted time. The parties were ordered to share a half hour of Dr. Betz's time. Dr. Betz's rate for testimony is $750/hour. Therefore, Claimant's half of an half hour of time is $187.50. Claimant is hereby ordered to reimburse Employer's third-party administrator, CCSMI, within ten (10) days of entry of this order, for expert fees paid to Dr. Betz in the amount of $187.50.

DECISION

As to Appeal No. 1900471-RKN, the Hearing Officer Decision dated July 19, 2018 is hereby REVERSED. The underlying determinations dated May 24, 2018 and June 13, 2018 are AFFIRMED. Employer's third-party administrator properly offered Claimant a 6% PPD award following apportionment of the 25% PPD award as 75% non-industrial and 25% industrial, based on Dr. Anderson's PPD evaluation and Dr. Betz's records review report.

As to Appeal No. 1902049-RKN, this appeal is found to be resolved and the issue deemed moot pursuant to the parties' agreement as to payment of the installment payments pursuant to NRS 616C.380. The determination letter dated January 24, 2019 reflecting the parties' agreement was not appealed and is considered a final determination resolving the issue on appeal.

As to Appeal No. 1802418-RKN, the appeal is found to be resolved and the issue deemed moot pursuant to the Appeals Officer's Order Lifting the Stay and directing a second PPD evaluation. The completion of the second PPD evaluation by Dr. Jempsa resolved the issue on appeal rendering the appeal moot.

The claim was properly closed as of the May 8, 2018 date of Dr. Jempsa's PPD evaluation. Claimant was properly awarded a 6% PPD award, following apportionment of the 25% PPD award by Dr. Anderson, and as affirmed by Dr. Betz, which apportioned the whole person impairment as 75% non-industrial and 25% industrial. The Claimant may elect to accept her 6% PPD award in lump sum as awarded in the affirmed June 13, 2018, if she desires. Installment payments made since the date of offer can be properly deducted. The Insurer shall issue a lump sum offer with an updated calculation setting forth such deductions for installments paid.

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Claimant shall pay to Employer, through payment to third-party administrator, within ten days from the date of this order, the amount of $187.50 for expert fees incurred on behalf of Claimant at the appeal hearing.

DATED this 19th of August, 2019

APPEALS OFFICER

Submitted by:
LISA WILTSHIRE ALSTEAD
MCDONALD CARANO LLP

100 West Liberty St., 10th Floor
Reno, Nevada 89501

Notice: Pursuant to NRS 233B.130 should any party desire to appeal this final decision of the Appeals Officer, a Petition for Judicial Review must be filed with the district court within thirty (30) days after service by mail of this Decision.

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing ORDER was deposited into the State of Nevada Interdepartmental mail system, **OR** with the State of Nevada mail system for mailing via United States Postal Service, **OR** placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 1050 E. Williams Street, Suite 450, Carson City, Nevada, 89701 to the following:

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Dated this 21st day of August, 2019.

Brandy Fuller

Brandy Fuller, Legal Secretary II
Employee of the State of Nevada

NEVADA DEPARTMENT OF ADMINISTRATION

BEFORE THE APPEALS OFFICER

In the Matter of the: Contested Industrial Insurance Claim, of KIMBERLY KLINE, Claimant	Claim No.: 15853E839641 Hearing No.: 1803718-JL 1803717-JL 1901522-JL Appeal No.: 1900471-RKN 1902049-RKN 1802418-RKN

TRANSCRIPT OF PROCEEDINGS

BEFORE THE

HONORABLE RAJINDER K. NIELSEN, ESQ.

APPEALS OFFICER

MAY 1, 2019

9:32 AM

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CARSON CITY, NEVADA 89701

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I N D E X

E X H I B I T S

P R O C E E D I N G S

APPEALS OFFICER: Okay, good morning. I'm Appeals Officer Nielsen. Today is May 1, 2019. It's approximately 9:30 in the morning. We're here in regards to three consolidated appeals involving the Claimant, Kimberly Kline. These are Appeal #1802418, 1902049, and 1900471.

The Claimant, Kimberly Kline, is here in person. On her behalf we have Mr. Herb Santos present. The Employer in this matter is the City of Reno, Police Department. The Insurer is CCMSI. On their behalf, we have Ms. Lisa Alstead present. Also present is a representative of CCMSI is Lisa Jones and Andrena Erique [phonetic] as a representative of the City of Reno.

Prior to going on the record, Ms. Alstead indicated that neither Ms. Jones or Ms. Erique are testifying today, so they can go ahead and remain in the room for the duration of the proceeding as respective representatives of the Insurer and Employer.

Appeal #1802418 originally came before the Appeals Officer, literally a year ago on May 2, 2018. At that time, we went on the record briefly to mark and enter a series of four Exhibits. These are Claimant's First Index of Documents, filed April 26, 2018, which consisted of 224 pages. Insurer's Documentary Evidence filed February 14, 2018, consisting of 182 pages. Insurer's First Supplemental Documentary Evidence,

filed April 17, 2018, consisting of one page which was marked and entered as Exhibit 3. Finally we had an Insurer's Second Supplemental Documentary Evidence Packet, consisting of six pages filed April 26, 2018, which was marked and entered as Exhibit 4.

At the time of the hearing on Appeal 1802418, the matter was continued and we briefly went on the record to mark and enter the various Exhibits and to hear the Insurer's renewed Motion for Stay. Subsequently, Appeal 1902049 and 1900471 were filed with the Appeals Office and were consolidated.

So at this time, we'll proceed to hearing on 1802418 which was Employer's—is Employer's appeal filed on February 14, 2018 of a Hearing Officer decision dated January 16, 2018 which remanded the initial determination of the Insurer which was a 6% PPD issued on December 5, 2017.

On—in regards to Appeal 1902049, this is Claimant's appeal that was filed on January 10, 2019. At issue is a December 27, 2018 Hearing Officer decision which affirmed and remanded a September 20, 2018 determination issued by the Insurer, which was the 27% PPD award. Specifically, the Hearing Officer had concerns under 616C.380(1)(a), as to what format that payment should've taken.

Subsequently, on—under Appeal 1900471, this is the Employer's appeal that was filed on August 14, 2018. At issue

is a July 19, 2018 Hearing Officer decision which reversed the June 13, 2018 and May 24, 2018 determinations issued by the Insurer, which were the 6% PPD and holding of the 27% in abeyance.

For today's hearing, we have additional exhibits. Starting with the Claimant, we have Claimant's Index of Documents, Claimant's First Supplemental, Claimant's Second Supplemental. Ms. Alstead, do you have any objection to these three coming in?

LISA ALSTEAD: Your Honor, no objection. I just wanted to note in the 418 matter, there's some additional exhibits that were filed after—so, I'm assuming you're referring to the 471 matter right now, is that correct?

APPEALS OFFICER: It's both of the other two, yeah.

LISA ALSTEAD: Okay. Okay.

APPEALS OFFICER: So, yes.

LISA ALSTEAD: No objection, Your Honor.

APPEALS OFFICER: Okay, thank you. Claimant's Index of Documents filed January 7, 2019, consisting of 244 pages will be marked and entered as Exhibit A. Claimant's First Supplemental Index of Documents filed June 11, 2018, consisting of 27 pages; noting it only references 1802418. This will be marked and entered as Exhibit B. I see what you're saying, Ms. Alstead. I'm just going to go ahead and

mark them all alphabetically at that point. Anything we didn't admit at the prior.

HERB SANTOS: And that was the 27 page one, Your Honor?

APPEALS OFFICER: Yes. And then, Claimant's Second Supplemental consisting of 31 pages, filed November 5, 2018 will be marked and entered as Exhibit C. This one again references Appeal 1802418.

We then have additional Exhibits from the Insurer. We have an Insurer's Documentary Evidence Packet, Insurer's First Supplemental, Second, Third, Fourth, Fifth, and then another one that's marked Fifth, which should be Sixth, is that correct, Ms. Alstead?

LISA ALSTEAD: Yes, under the 41—those were filed under the 418, yes, Your Honor.

APPEALS OFFICER: Okay. I'm just going to mark on the top that it's Six. And I'll note they all reference the various appeals. Okay. So, starting with Insurer's Documentary Evidence Packet, filed August 14, 2018, consisting of 222 pages. This will be marked and entered as Exhibit D.

Insurer's First Supplemental, consisting of two pages, filed April 15, 2019 will be marked and entered as Exhibit E. Insurer's Second Supplemental consisting of one page, filed April 30, 2019—

HERB SANTOS: Okay, hold on a second.

LISA ALSTEAD: That's the one I had to give you a copy of because we in fact filed it yesterday and Your Honor had a copy of [inaudible] I wanted to confirm as well.

APPEALS OFFICER: It's the Insurer's Determination dated—

HERB SANTOS: Gotcha, okay.

APPEALS OFFICER: --January 24, 2019. That will be marked and entered as Exhibit F. Insurer's Third Supplemental Documentary Evidence Packet consisting of 24 pages, filed May 29, 2018 will be marked and entered as Exhibit G. Insurer's Fourth Supplemental, consisting of one page, which is the June 4, 2018 report from Dr. Betz, filed June 11, 2018.

HERB SANTOS: I think that's correspondence, Your Honor.

APPEALS OFFICER: Oh, okay. Will be marked and entered as Exhibit H. Insurer's Fifth Supplemental Documentary Evidence Packet—it indicates one page but obviously has a lot more. It looks like 183 pages, filed June 20, 2018 will be marked and entered as Exhibit I. Insurer's Fifth Supplemental Documentary Evidence Packet consisting of one page correspondence dated May 29, 2018, filed June 11, 2018 has been corrected to reflect Employer's Sixth Supplemental Documentary Evidence Packet and will be marked and entered as Exhibit J.

In the interest of ensuring we get through our witnesses in a timely manner, are the two of you okay with just reserve—with holding back on opening and just doing it altogether as part of the closing argument?

HERB SANTOS: Yes, that's fine, Your Honor.

LISA ALSTEAD: Yes, Your Honor.

HERB SANTOS: I don't have J.

APPEALS OFFICER: You what?

HERB SANTOS: I don't have J. What is J?

APPEALS OFFICER: It's a May 29, 2018 letter to Dr. Betz from CCMSI. It says, Dear Dr. Betz. Enclosed please find a copy of the complete medical file. After review, please provide your opinion on apportionment.

HERB SANTOS: Okay, so I—

APPEALS OFFICER: Thank you for your time and consideration.

HERB SANTOS: I think you may have actually—what is—what do you have for H? Isn't that the same thing?

APPEALS OFFICER: No, that had a different date. That is a June 4, 2018—that's the actual chart review he did. And that is not one page. It says one page on the index. It is actually six pages in the entirety of this report. [pause]

HERB SANTOS: [inaudible]

LISA ALSTEAD: I think I'm confused. It's because we had the two Fifth packets. So for J, do you have—

was it called Insurer's Fifth Supplement and we changed it to Employer's Sixth?

APPEALS OFFICER: Yeah. That was the May 29th one page letter to Dr. Betz.

LISA ALSTEAD: Okay, got it.

APPEALS OFFICER: And then H, it says one page on the index. It's actually—

LISA ALSTEAD: It's the medical file.

APPEALS OFFICER: It's actually six pages and includes Dr. Betz' June 4, 2018 PPD chart review.

HERB SANTOS: I've got that, that's somewhere else in mine. So, that's the only one that J has.

APPEALS OFFICER: H.

HERB SANTOS: Or, H has.

APPEALS OFFICER: Correct.

HERB SANTOS: I'll be okay.

APPEALS OFFICER: It's also, I gave you guys the Exhibits ahead of time. Do you have it?

HERB SANTOS: I just—yeah, I just numbered these things wrong.

APPEALS OFFICER: Okay.

HERB SANTOS: That's—

APPEALS OFFICER: It says, June 4th.

HERB SANTOS: Yeah and that is H?

APPEALS OFFICER: Yes.

HERB SANTOS: Thank you, sorry.

APPEALS OFFICER: Okay, not a problem. All right. So at this time, Mr. Santos, your first witness.

HERB SANTOS: Go ahead, Ms. Kline, take the stand.

APPEALS OFFICER: Good morning Ms. Kline, how are you?

KIMBERLY KLINE: Good morning, well, thank you.

APPEALS OFFICER: Good. I will start—where is the microphone? They shampooed in here so, and they[inaudible]. Thank you Mr. Santos. Okay. Ms. Kline, I'll start by swearing you in, if you could please raise your right hand. Do you solemnly swear or affirm the testimony you're about to give will be the truth, the whole truth and nothing but the truth?

KIMBERLY KLINE: I do.

APPEALS OFFICER: Thank you. Can you please state and spell your full name for the record?

KIMBERLY KLINE: Kimberly Kline, it's K-I-M-B-E-R-L-Y. Kline is, K-L-I-N-E.

APPEALS OFFICER: Okay, thank you, Ms. Kline. Both Mr. Santos and Ms. Alstead will have an opportunity to ask you some questions. We do audio record the duration of the proceeding in order to preserve the record. So, I would ask you speak clearly towards the microphone. Clear, verbal

yes/no type answers. No head nods or uh huhs. Also, please wait for each question to be asked to completion before responding so we avoid a record of individuals speaking over one another.

KIMBERLY KLINE: Okay.

APPEALS OFFICER: Okay. Mr. Santos, you may proceed. I will leave it open for a period of two or three weeks if you want to supplement the record or verify that the initial testimony from the underlying hearing is filed—

HERB SANTOS: It is.

APPEALS OFFICER: --but if you want part it of the record—where is it in the record?

HERB SANTOS: It's going to be in [pause]

APPEALS OFFICER: So we do already have it?

HERB SANTOS: Yeah.

APPEALS OFFICER: Okay.

HERB SANTOS: I believe it's in Exhibit A.

APPEALS OFFICER: Okay, thank you. Where in A?

HERB SANTOS: Pages [pause] 171—

APPEALS OFFICER: Okay.

HERB SANTOS: --through 199.

APPEALS OFFICER: 199, okay, thank you so much. All right. So, go ahead and proceed. As I indicated before going on the record, there is prior testimony as to injury,

all of that, that was dealt with at a prior hearing, with the focus of today on the PPD.

HERB SANTOS: Thank you, Your Honor.

APPEALS OFFICER: All right, go ahead, Mr. Santos.

HERB SANTOS: Ms. Kline, prior to June 25th, were you ever advised by any healthcare provider that you had cervical disc herniations?

KIMBERLY KLINE: No.

HERB SANTOS: How about disc protrusions?

KIMBERLY KLINE: No.

HERB SANTOS: How about disc extrusions?

KIMBERLY KLINE: No.

HERB SANTOS: How about disc bulges?

KIMBERLY KLINE: No.

HERB SANTOS: At any time prior to June 25, 2015, did any healthcare provider recommend cervical surgery to you?

KIMBERLY KLINE: No sir.

HERB SANTOS: Prior to June 25, 2015, did any healthcare provider advise you that you needed treatment for any type of disc herniation in your cervical spine?

KIMBERLY KLINE: No.

HERB SANTOS: Prior to June 25, 2015, did you ever have any diagnostic testing that confirmed, or that-

strike that. Did you ever have an MRI prior to June 25, 2015 for your neck?

KIMBERLY KLINE: No.

HERB SANTOS: You did receive treatment for your lower back, prior to this, June 25th?

KIMBERLY KLINE: Yes.

HERB SANTOS: Do you recall seeing a doctor in an orthopedic clinic in May 2015?

KIMBERLY KLINE: I do.

HERB SANTOS: Do you recall whether or not you had any neck complaints at that visit?

KIMBERLY KLINE: I did not.

HERB SANTOS: Do you recall what your complaints were at that visit?

KIMBERLY KLINE: My lower back.

HERB SANTOS: You were involved in an automobile accident on June 5th, while you were at work?

KIMBERLY KLINE: June 3rd.

HERB SANTOS: Oh, June 3rd, I'm sorry. 2015?

KIMBERLY KLINE: Correct.

HERB SANTOS: About a month before this accident, [inaudible] here today?

KIMBERLY KLINE: Yes.

HERB SANTOS: And, did you have any neck complaints as a result of that accident?

KIMBERLY KLINE: I did have muscle strain after the accident.

HERB SANTOS: Did you receive any treatment during that month for any injury to your neck?

KIMBERLY KLINE: Yes, I was undergoing treatment with Specialty Health.

HERB SANTOS: Was there any type of diagnosis that you had any type of herniation, disc protrusion, extrusion or anything abnormal with your cervical [inaudible]?

KIMBERLY KLINE: No.

HERB SANTOS: Was the majority of your treatment was around your low back.

KIMBERLY KLINE: Yes.

HERB SANTOS: That's all I have.

APPEALS OFFICER: Thank you Mr. Santos. Ms. Alstead?

LISA ALSTEAD: I have no questions, Your Honor.

APPEALS OFFICER: Okay. Thank you. Anything else you were holding on, Mr. Santos?

HERB SANTOS: That's it.

APPEALS OFFICER: Okay, thank you, Ms. Kline. You can return to your seat.

KIMBERLY KLINE: Thank you.

HERB SANTOS: I would ask the Court to give us [inaudible]

APPEALS OFFICER: No, thank you.

HERB SANTOS: That doesn't normally happen.

APPEALS OFFICER: Yes. Okay. Your—any additional witnesses, Mr. Santos?

HERB SANTOS: No, Your Honor.

APPEALS OFFICER: Thank you. Ms. Alstead, your witness?

LISA ALSTEAD: Yes, Your Honor. And, before we call him, I just wanted to again tell you what Exhibits we had so we're all prepared.

APPEALS OFFICER: Okay.

LISA ALSTEAD: So, he has—he has a portion of what has been marked Exhibit C and it's Pages 24-31 or I'm sorry, 26-31. It's his CV. So, he has a copy of that. He has a copy of what has been marked Exhibit H. And please tell me if I have these wrong, but that should be a copy—

APPEALS OFFICER: Of his report.

LISA ALSTEAD: --of his records review report. And then he has a copy of Exhibit J, which should be his medical file. Let me make sure I have that right. Maybe—

APPEALS OFFICER: Let me find—I think it's—

LISA ALSTEAD: --or, I, is it I?

APPEALS OFFICER: Okay, yes, I.

LISA ALSTEAD: I apologize. Okay. So, Exhibit—he has a portion of C, which is his CV. He has

Exhibit H, which is his records review report and then Exhibit I, which is his medical file.

APPEALS OFFICER: Okay, so not J, I.

LISA ALSTEAD: I apologize. Yeah, just I.

APPEALS OFFICER: And that is what's represented as a copy of the medical file provided to Dr. Betz for records review.

LISA ALSTEAD: Yes.

APPEALS OFFICER: One second. Is that it?

LISA ALSTEAD: That is it, Your Honor.

APPEALS OFFICER: Okay, thank you. Thank you for providing those to him.

LISA ALSTEAD: Yes. [pause] And then one more thing, I just want to confirm on the record that we've stipulated to him being an expert. I may ask him just real basic introductory, but we'll skip going through the hoops of qualifying him, if that's agreeable with Mr. Santos.

APPEALS OFFICER: Is that agreeable to you, Mr. Santos?

HERB SANTOS: I'll stipulate that he's a doctor and he does ratings.

APPEALS OFFICER: Okay. And, I have—I will treat him as an expert qualified to address PPD questions and ratings and evaluations and apportionment.

LISA ALSTEAD: Thank you, Your Honor.

APPEALS OFFICER: All right. Let me just grab H, I and C. [pause] Okay. Do you have a phone number for him?

LISA ALSTEAD: Yes, it is 775.

APPEALS OFFICER: Why don't you just write it down and hand it to me.

LISA ALSTEAD: Okay.

APPEALS OFFICER: And I have some post-its here.

LISA ALSTEAD: Let me grab a post-it from you. [pause]

APPEALS OFFICER: Okay, thank you. [dials phone, rings] Hi, Dr. Betz? This is Appeals Officer Nielsen; how are you today?

DR. JOHN BETZ: I'm well, thank you.

APPEALS OFFICER: Good. I have you on speaker. We are audio recording. I'm here with Mr. Santos, the Claimant in this matter, Ms. Kline, Ms. Alstead who is representing the Employer and Insurer, and additionally, we have in the room Ms. Jones from CCMSI and Ms. Erique from the City of Reno.

So we are on the record and at this time, we would-I would like the parties to ask you some questions. Can you hear me okay?

DR. JOHN BETZ: I can.

APPEALS OFFICER: Okay.

DR. JOHN BETZ: I'm on speakerphone also, can you hear me all right?

APPEALS OFFICER: Yes, thank you.

DR. JOHN BETZ: Okay.

APPEALS OFFICER: So, prior to going on the record, Ms. Alstead indicated that you have Exhibits—you have your CV, a copy of your June 4, 2018 report and a packet of records that were given to you to review. That packet should be entitled Insurer's Fifth Supplemental Documentary Evidence Packet.

DR. JOHN BETZ: Yes, I have that all.

APPEALS OFFICER: Okay. I will go ahead and swear you in. If you could please raise your right hand.

DR. JOHN BETZ: Go ahead.

APPEALS OFFICER: Do you solemnly swear or affirm the testimony you're about to give will be the truth, the whole truth and nothing but the truth?

DR. JOHN BETZ: I do.

APPEALS OFFICER: Thank you. Can you please state and spell your full name for the record?

DR. JOHN BETZ: John Jay Edward Betz. John, J-O-H-N, Jay, J-A-Y, Edward, E-D-W-A-R-D, Betz, B-E-T-Z.

APPEALS OFFICER: Okay. Thank you Dr. Betz. I know you've testified in these types of matters before. We are having you testify by phone, so just pause for a second or

two before responding so we avoid a record of individuals speaking over one another and we can address any objections as they come up.

In addition to the records we just discussed, do you have anything else in front of you, in terms of documents?

DR. JOHN BETZ: I have the AMA Guides and a copy of the apportionment, Administrative Code, NAC 616C.490.

APPEALS OFFICER: Okay, thank you. All right. I'm going to go ahead and turn you over to Ms. Alstead. I will indicate to both parties, as we discussed before, in the interest of time, I'm willing to accept the party's stipulation that Dr. Betz is familiar with PPDs, apportionment and I will treat him accordingly as an expert witness, without going through the normal foundation. We do have a copy of his CV available. Go ahead, Ms. Alstead.

LISA ALSTEAD: Thank you, Your Honor. Dr. Betz, as the Appeals Officer confirmed with you, you have a copy of your CV before you, correct?

DR. JOHN BETZ: I do.

LISA ALSTEAD: And, for our purposes, that's been marked as Exhibit C and starts at Page 26. Can you just confirm that the information in your CV is correct and accurate?

DR. JOHN BETZ: Sure. Let me go to Section 3 of my binder. [pause] Yes. It appears accurate.

LISA ALSTEAD: [pause]

DR. JOHN BETZ: Yes, it appears accurate.

LISA ALSTEAD: Thank you. And, as the Appeals Officer indicated, we've agreed that you are qualified, but just very briefly, can you tell me what experience you have in performing records reviews?

DR. JOHN BETZ: Well, I've been practicing occupational medicine for about 30 years. I became a Certified Independent Medical Examiner soon after that. I've been doing impairment evaluations in the State of Nevada for the majority of that time and I was on the peer review committee for the State regarding impairment evaluations. I was on their inaugural Board. I periodically receive requests to review impairment evaluations performed by others just to review the accuracy and the appropriateness of the conclusions. So, I've been doing that for over 20 years.

LISA ALSTEAD: Okay. And you indicated that you have the AMA Guides in front of you; are you familiar with the AMA Guides?

DR. JOHN BETZ: Very.

LISA ALSTEAD: And you also indicated you have Nevada's apportionment statute, or I apologize, regulation, NAC 616C.490. Are you familiar with that regulation?

DR. JOHN BETZ: I am.

LISA ALSTEAD: All right. I'm going to have you turn to what, for our purposes has been marked as Exhibit I. It's the copy of the medical file that was sent to you for your records review.

DR. JOHN BETZ: Okay. [pause]

LISA ALSTEAD: Can you tell me, what records you relied upon out of this medical file in performing your apportionment analysis?

DR. JOHN BETZ: Sure. So everything in the binder looks familiar to me, starting with a note, a little bit out of chronological order, but a note from Dr. Menure [phonetic] about five or six weeks before the subsequent occupational injury and going through until post-surgical, rehabilitation, followed by the impairment evaluation. I believe Dr. Anderson was first and then Dr. Kimsell [phonetic] was second.

LISA ALSTEAD: Okay. You mentioned Dr. Menure. I'm going to have you turn to what is bate stamped Page 10, in that package.

DR. JOHN BETZ: Okay.

LISA ALSTEAD: It should be a report dated May 11, 2015. Do you see that?

DR. JOHN BETZ: I do.

LISA ALSTEAD: In Dr. Menure's reporting, he indicated—he gave his impression of the Claimant's condition.