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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

APPELLANT'S REPLY BRIEF

Petition for Judicial Review Decision of
The Honorable Connie Steinheimer of the Second Judicial District Court
Reviewing the Decision of the Honorable Rajinder Nielsen, Esq.,
Appeals Officer of the Department of Administration
Hearings Division, State of Nevada

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ARGUMENT

I. THE CLAIMANT'S CLAIM IS NOT CURRENTLY CLOSED AS THE INSURER NEVER CLOSED THE CLAIM UNDER NRS 616C.235.

The Respondent contends that Appellant's claim is closed. The Respondent states that the Appellant failed to appeal claim closure. The Respondent alleges that the April 4, 2018 PPD scheduling letter was a claim closure letter. This contention is without merit.

Nevada law is clear as to how and when an industrial claim closes. NRS 616C.235 states as follows:

> **NRS 616C.235 Closure of claim by insurer: Procedure; notice; special procedure if medical benefits less than $800.**
>
> 1. Except as otherwise provided in subsections 2, 3 and 4:
>
> (a) When the insurer determines that a claim should be closed before all benefits to which the claimant may be entitled have been paid, the insurer shall send a written notice of its intention to close the claim to the claimant by first-class mail addressed to the last known address of the claimant and, if the insurer has been notified that the claimant is represented by an attorney, to the attorney for the claimant by first-class mail addressed to the last known address of the attorney. The notice must include, on a separate page, a statement describing the effects of closing a claim pursuant to this section and a statement that if the claimant does not agree with the determination, the claimant has a right to request a resolution of the dispute pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive, including, without limitation, a statement which prominently displays the limit on the time that the claimant has to request a resolution of the dispute as set forth in NRS 616C.315. A suitable form for requesting a resolution of the dispute must be enclosed with the notice. The closure of a claim pursuant to this subsection is not effective unless notice is given as required by this subsection.
>
> (b) If the insurer does not receive a request for the resolution of the dispute, it may close the claim.
>
> (c) Notwithstanding the provisions of NRS 233B.125, if a hearing is conducted to resolve the dispute, the decision of the hearing officer may be served by first-class mail.
>
> 2. If, during the first 12 months after a claim is opened, the medical benefits required to be paid for a claim are less than $800, the insurer may close the claim at any time after the insurer sends, by first-class mail addressed to the last known address of the claimant, written notice that includes a statement which prominently displays that:
>
> (a) The claim is being closed pursuant to this subsection;
>
> (b) The injured employee may appeal the closure of the claim pursuant to the provisions of NRS 616C.305 and 616C.315 to 616C.385, inclusive; and
>
> (c) If the injured employee does not appeal the closure of the

claim or appeals the closure of the claim but is not successful, the claim cannot be reopened.

3. In addition to the notice described in subsection 2, an insurer shall send to each claimant who receives less than $800 in medical benefits within 6 months after the claim is opened a written notice that explains the circumstances under which a claim may be closed pursuant to subsection 2. The written notice provided pursuant to this subsection does not create any right to appeal the contents of that notice. The written notice must be:

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

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

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

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

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

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

(Added to NRS by 1979, 707; A 1981, 1140, 1492; 1989, 333; 1991, 2421; 1993, 746; 1997, 1437; 1999, 1783, 2416; 2001, 115; 2007, 3349; 2009, 1282; 2017, 1162)

In order to close a claim in compliance with NRS 616C.235, an industrial insurer must comply with the following statutory mandates:

1. The insurer shall send a written notice of its intention to close the claim to the claimant;
2. The notice must include, on a separate page, a statement describing the effects of closing a claim pursuant to NRS 616C.235;
3. A statement that if the claimant does not agree with the determination, the claimant has a right to request a resolution of the dispute pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive, including, without limitation, a statement which prominently displays the limit on the time that the claimant has to request a resolution of the dispute as set forth in NRS 616C.315; and

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4. A suitable form for requesting a resolution of the dispute must be enclosed with the notice.

A review of the April 4, 2018 letter confirms that the PPD scheduling letter does not include the mandatory requirements of NRS 616C.235. The Respondent is well aware NRS 616C.235 as they issued claim closure letters two (2) times prior to the PPD scheduling letter during the course of the claim. ***AA 425, AA 501.*** The first was rescinded and the second was reversed. NRS 616C.235 is very clear that "the closure of a claim pursuant to this subsection is not effective unless notice is given as required by this subsection." NRS 6126C.235(1)(a).

The Respondent's contention that the claim was closed by the PPD scheduling letter is without merit. The ongoing appeal of the PPD determination renders the claim open and absent a proper claim closure letter pursuant to NRS 616C.235, the claim has never closed.

II. SB 289 CLARIFIES NRS 616C.490 AND THEREFORE HAS RETROACTIVE EFFECT.

When an amendment clarifies, rather than substantively changes a prior statute, the amendment has retroactive effect. ***Fernandez v. Fernandez***, 126 Nev. 28, 35 n.6, 222 P.3d 1031, 1035 n.6 (2010); see also ***In re Estate of Thomas***, 116 Nev. 492, 495, 998 P.2d 560, 562 (2000) (explaining that "[w]here a former statute is amended, or a doubtful interpretation of a former statute rendered certain by subsequent legislation, it has been held that such amendment is persuasive evidence of what the Legislature intended by the first statute" (alteration in original) (quoting ***Sheriff, Washoe Cty. v. Smith***, 91 Nev. 729, 734, 542 P.2d 440, 443 (1975)); **1A Norman J. Singer & J.D. Shambie Singer, Sutherland Statutory Construction** § 22.34 (7th ed. 2009) ("Where an amendment clarifies existing law but does not contravene previous constructions of the law, the amendment may be deemed curative,

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remedial and retroactive, especially where the amendment is enacted during a controversy over the meaning of the law."). ***Delucchi v. Songer***, 133 Nev., Advance Opinion 42.

The apportionment component of NRS 616C.490, on the date of the PPD of the Appellant, states as follows:

> 9. Except as otherwise provided in subsection 10, if there is a previous disability, as the loss of one eye, one hand, one foot, or any other previous permanent disability, the percentage of disability for a subsequent injury must be determined by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury.
>
> 10. If a rating evaluation was completed for a previous disability involving a condition, organ or anatomical structure that is identical to the condition, organ or anatomical structure being evaluated for the present disability, the percentage of disability for a subsequent injury must be determined by deducting the percentage of the previous disability from the percentage of the present disability, regardless of the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted by the Division pursuant to NRS 616C.110 used to determine the percentage of the previous disability. The compensation awarded for a permanent disability on a subsequent injury must be reduced only by the awarded or agreed upon percentage of disability actually received by the injured employee for the previous injury regardless of the percentage of the previous disability.

Thus, the law at the time of the PPD stated that the impairment from the pre-existing condition had to be calculated and then subtracted from the industrial rating. The regulation, NAC 616C.490, had similar language in section 4 which stated

> 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

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disease.

Section 5 only applies when a rating doctor does not have precise information available to determine an apportionment using the **AMA Guides, 5th Edition**. Due to some rating doctors failure to follow the regulation and misapply Section 5, SB 289 was enacted to stop the misapplication of NAC 616C.490. The replacement language for apportionment of PPD ratings essentially merged NRS 616C.490 and NAC 616C.490. The rule is 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;

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(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.

These changes clarified the existing apportionment rules of NRS 616C.490 and NAC 616C.490 and combined the two. As stated by Jason Mills during the legislative hearings of SB 289,[1]

Senate Committee on Commerce and Labor
April 2, 2021

Section 1 deals with the concept of apportionment in workers' compensation. Prior injuries are typically subtracted from an award. If you had a prior shoulder injury with an award, your award for a new injury on the job should be reduced. The language drafted in the apportionment part of the bill conforms to this concept and clarifies exactly how apportionment should take place. This aligns Nevada law with most other states and removes confusion. ***AA 2175.***

Assembly Committee on Commerce and Labor
May 7, 2021

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[1] A complete copy of the minutes of the legislative hearings relevant to SB 289 are attached in ***AA Volume 10, pages 2175-2192.***

> First and foremost is that sections 1 and 7 are dealing with what is called the apportionment of permanent partial disability (PPD) and forced installments. Permanent partial disability awards are at the end of cases. Current case law basically says if you have prior injury or prior award, if the same body part is indicated, then the reward would be apportioned or reduced. That is existing law. What we are looking to do in sections 1 and 7 is to further clarify exactly how apportionment should be done. Specifically, how the apportionment should be done, through prior PPDs, or if there are existing medical records that would show that a person had an actual impairment prior to the injury. Finally, if there were no medical records available, there is a section in the bill, namely section 1, subsections 4 and 5, that indicates evidence of a prior surgery would allow for apportionment. ***AA 2185.***

SB 289 passed the Senate unanimously and also passed unanimously in the Assembly with one member absent. ***AA 2193.***

It is clear that Section 1 of SB 289 clarified, rather than substantively changed, NRS 616C.490. The purpose of the amendment to NRS 616C.490 was to make it clear that you determine the pre-existing impairment under the **AMA Guides, 5th Edition** and subtract it from the industrial rating. Nothing changed substantively. The amendment effectively repealed NAC 616C.490 and prevented the misapplication of the regulation by certain insurance companies and rating doctors which resulted in manipulating the regulation which effectively resulted in the regulation exceeding its statutory authority.

It is also clear that the SB 289 is intended to apply to all open claims. Section 11 states:

> 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. ***AA 49.***

In fact, the Respondent concedes this issue as they contend that in the event this Court finds that SB 289 applies, the matter should be "remanded to the Appeals Officer for a new hearing which considers the new law on apportionment." ***Answering Brief, page 38.***

Based upon the above, the amendment to NRS 616C.490 has retroactive effect and applies to the Appellant's PPD rating.

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III. RESPONDENT'S ARGUMENT CONCEDES THAT THE APPORTIONMENT OF 75% WAS NOT IN COMPLIANCE WITH NRS 616C.490 AND NAC 616C.490.

The Respondent's Answering Brief confirms that the Appeals Officer ignored the mandate of NAC 616C.490 that the rating doctor determine the pre-existing impairment under the **AMA Guides, 5th Edition** and then, under NAC 616C.490 and NRS 616C.490, subtract that impairment rating from the current rating. Starting at page 21of the Respondent's Answering Brief, the Respondent confirms that the first rating doctor (Dr. Anderson), and the Respondent's paid expert, Dr. Betz, never determined the actual pre-existing impairment. All Dr. Betz stated was that at least 50% of the present impairment was due to the pre-existing condition. There is absolutely no evidence in the record that Dr. Anderson or Dr. Betz were "unable to determine an apportionment using the Guides as set forth in subsection 4."[2] It is a mandatory requirement for the rating doctor to determine what the impairment would have been immediately prior to the industrial accident. It is only when they cannot make that determination that they leave section 4 of NAC 616C.490 and consider apportionment under NAC 616C.490(5). You cannot jump that important step. We know that Dr. Betz confirmed that there would have been no ratable impairment for the pre-existing condition. Dr. Betz testified:

> HERB SANTOS: Okay. Isn't it true that there is no medical evidence that minutes before the car accident, Ms. Kline had a ratable impairment under AMA Guides, Fifth Edition.

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[2] The Respondent actually bolds and underlines the language of the regulation which requires a finding that the rating physician is unable to determine an apportionment using the **AMA Guides** before the remainder of Section 5 is applicable. ***Answering Brief, page 19.***

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...

DR. JOHN BETZ: That's correct. No evidence of a ratable impairment. She clearly had an impairment, but not a ratable one.

AA 293.

NRS 616C.110 states that the Division must adopt the **AMA Guides, 5th Edition**. The rule further states that the **AMA Guides, 5th Edition** must be applied to all PPD examinations and that the regulations adopted by the Division must be consistent with the **AMA Guides, 5th Edition**. The Respondent points out the beginning instructions in the Guides as to apportionment. ***Answering Brief, page 21.*** The Respondent, however, fails to turn the page and note the clear explanation of apportionment on page 12 which clarifies the "process" for the "framework" for apportionment for spine injuries. At page 12 of the **AMA Guides, 5th Edition** under the section titled, 1.6b Apportionment Analysis:

> For 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. ***AA 2196.***

It is clear from the record that Dr. Anderson did not follow the instructions on apportionment from the **AMA Guides, 5th Edition** or that he followed NRS 616C.490 and NAC 616C.490(4) correctly. The Appeals Officer's reliance on Dr. Anderson's opinions, which are clearly inconsistent with the law, results in reversible error. Further, the Appeals Officer's refusal to acknowledge her prior Decision which found that the disc herniations were industrially caused, results in error of law under the doctrine of issue preclusion. Given Dr. Betz's opinion that if the disc herniations were industrially caused there would be no apportionment, as a matter of law, the

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subject rating should not have resulted in any apportionment.

The Appeals Officer's acceptance of the 75% apportionment is an abuse of discretion given that the 75% is nothing more than mere speculation. What was the methodology used by Dr. Anderson to arrive at the 75%? There was none. The record is absent of any evidence that he calculated the impairment of the pre-existing condition pursuant to the **AMA Guides, 5th Edition**. The second rating completed by Dr. Jemspa clearly complied to the **AMA Guides, 5th Edition** and the rules, in effect then and in effect now, as to apportionment.

Since the Appeals Officer's Decision is based upon an apportionment which was not completed in compliance with the **AMA Guides, 5th Edition**, NRS 616C.490 and NAC 616C.490, the Decision should be reversed.

IV. THE APPEALS OFFICER'S DECISION IS NOT SUPPORTED BY THE LAW OR SUBSTANTIAL EVIDENCE.

The Respondent contends that the Appeals Officer not only followed the law, but that her Decision was supported by substantial evidence.

First, as to the law as it existed at the time of the Decision, there was a clear failure of the Appeals Officer to properly follow and apply the mandates of NRS 616C.490 and NAC 616C.490. The law requires the following methodology be used for apportionment:

Step 1. Since there was no prior rating for the cervical spine, Section 4 of NAC 616C.490 must be reviewed. The percentage of impairment for the preexisting condition and the present industrial injury must be recalculated by using the Guides, as adopted by reference pursuant to NAC 616C.002.

Step 2. Once both rating impairments are calculated, you subtract the percentage of impairment of the pre-existing condition from the percentage of impairment form the industrial injury.

The Appeals Officer did not follow the law because the PPD report she

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relies on [Dr. Anderson] did not address this first step. Dr. Anderson simply arbitrarily picked a number out of the air and divided that number as a percentage of what he thought was pre-existing. Nowhere in the rule is that calculation method allowed or suggested. Second, one only proceeds to Section 5 of NAC 616C.490 when two factors are met: precise information is not available and the rating physician is unable to determine an apportionment using the Guides as set forth in subsection 4. No where in Dr. Anderson's report does he state that he was unable to determine a rating under the **AMA Guides, 5th Edition**. It also appears that there is precise information of the pre-existing condition as both Dr. Anderson and Dr. Betz rely on the subsequent MRI to establish the pre-existing condition.

Finally, NRS 616C.490, as it existed at the time of the Decision, required the rating physician, "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(10). Note that the terms "disability" and "impairment of the whole person" are equivalent terms. NRS 616C.490(1). You have to calculate the impairment of both, period.

The Appeals Officer also supported her Decision on facts which were previously found by her to be unreliable, thus making her Decision arbitrary and capricious. The Appeals Officer relied on the opinions of Dr. Betz and Dr. Anderson that the Appellant cervical complaints after the industrial injury had resolved and then months later she exhibited new symptoms. Accepting this position was in complete disregard of the evidence and her prior findings in AO 56832-RKN. ***AA 373-382.*** The Appeals Officer previously found that

During the course of her treatment, the Claimant continued to complain

> of neck pain but was released from Dr. Hall, notwithstanding her complaints. Dr,. Hall did not order any diagnostic studies to determine the extent of her industrial injuries. The Claimant continued to experience neck pain and when it got to the point where the Claimant returned for treatment. When the Claimant was told that her claim was closed and could not be seen, she had no other alternative but to seek medical treatment on her own. 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. ***AA 379.***

It was already conclusively determined that the Appellant's industrial condition was not resolved and she had ongoing pain and symptoms. Dr. Anderson and Dr. Betz rejected those facts, generated their own facts to support their opinions on apportionment, and the Appeals Officer accepted the incorrect facts to support her Decision.

The Appeals Officer's reliance of Dr. Hall's opinion from his March 16, 2016 note is puzzling given that she gave no weight to those opinions in her prior Decision. ***AA 188.***

It should also be noted that the prior car accident referred to in the Appeals Officer's Decision and discussed numerous times by Dr. Betz was a work related car accident. ***AA 466.*** For reasons unclear, the Respondent did not officially open a claim for the first accident and when the second accident occurred, they then opened the current claim.

It is clear from the record that Dr. Anderson did not follow the law. It is clear from the record that Dr. Betz ignored the law in his record review. It is clear that the Appeals Officer also failed to follow the law, thus creating reversible error. In addition, the evidence the Appeals Officer relies on in supporting her Decision includes significant facts which she previously deemed unreliable and rejected. When you take those facts away from her Decision, there are no facts to support her Decision. The Respondent addresses this by contending that the prior decision does not preclude the Appeals Officer from taking "subsequent medical history and documentation

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into consideration when reaching the Decision at issue here." ***Answering Brief, page 29.*** The problem with that statement is that there is a legal rule called issue preclusion and second, there is no significant "subsequent medical history." The opinions regarding the scope of the claim pre-date the first decision. The prior Decision was the result of all medical treatment through and shortly after her cervical surgery. There is no legal authority submitted by the Respondent which would allow the Appeals Officer to re-litigate those issues.

For these reasons, the Appellant respectfully submits that the Decision is riddled with error of law and the Decision is not supported by substantial evidence.

V. THE RESPONDENT'S ATTEMPT TO REHABILITATE DR. BETZ'S TESTIMONY FAILS.

The Respondent attempts to rehabilitate the testimony of Dr. Betz by providing faulty testimony. Dr. Betz refused to accept, as conclusively proven, that the discs were industrially caused. The Appeals Officer had already made that finding in her prior Decision. The Appellant had disc protrusions at C4-5, C5-6 and C6-7, along with some degenerative changes in her cervical spine. The Appeals Officer found that the degenerative changes were aggravated and the industrial injury and that the discs were caused by the industrial injury. ***AA 380.*** There is no question that Dr. Betz refused to concede that the discs were caused by the industrial accident, but when faced with the questions where he had to take that fact as true, he had no alternative but to concede that it would change his opinion on apportionment.

The Respondent then incorrectly states that the **AMA Guides, 5th Edition** does not require evidence of a pre-existing impairment. Again, the Respondent needs to turn the page on the apportionment instructions of the Guides. The example provided by the **AMA Guides, 5th Edition**, clearly

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instructs the rating physician to determine the impairment under the Guides of the pre-existing condition and subtract it from the current rating.

Finally, as to Dr. Betz testimony recanted by the Respondent regarding the Appellant's prognosis for future surgery, the recommended types of surgery that she would need for various conditions, one question and his answer sums up the value of those opinions.

HERB SANTOS: How many spinal surgeries have you completed?

DR. JOHN BETZ: [laughs] None.

AA 293

It is clear from the record that Dr. Betz conceded that the Appellant had no ratable impairment in her cervical spine which predated the subject industrial injury. The Appeals Officer's Decision disregards this critical, necessary and mandatory fact which renders her decision flawed and results in reversible error.

VI. THE APPEALS OFFICER'S REJECTION OF DR. JEMPSA'S PPD REPORT DEMONSTRATES AN ABUSE OF DISCRETION.

The Respondent argues that the Appeals Officer properly disregarded Dr. Jempsa's PPD report. ***Answering Brief, page 30.*** Dr. Jempsa had the same records that Dr. Anderson and Dr. Betz reviewed for the Respondent. Dr. Jempsa did not review prior medical records of the cervical spine of the Appellant because there were none. Dr. Jemspa explained why there was no apportionment under NRS 616C.490. ***AA 823*** He determined that the whole person impairment for apportionment was 0%. ***AA 823.***

The Appeals Officer's disregard of Dr. Jempsa's rating based on the fact that there were no prior records of a cervical condition and the Appellant's testimony that she had no problems with her neck prior to the industrial claim is clearly an abuse of discretion. The record was clear that there were no prior medical records of cervical treatment. Dr. Anderson did

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not review any. Dr. Betz did not review any. The Appeals Officer's rejection of Dr. Jempsa, who followed the apportionment rules and regulations, demonstrates arbitrary and capricious conduct in disregard of the facts and the law. Couple her rejection of Dr. Jempsa, her failure to accept her prior conclusive findings regarding the scope of the claim, and her failure to properly apply the facts to the law, the finding of a 75% apportionment results in reversible error.

CONCLUSION

The law, in effect at the time of the ratings, was not followed. The rules mandated that the pre-existing condition be calculated and subtracted from the current rating. NRS 616C.490 mandates that process. NAC 616C.490(4) mandates that process. The **AMA Guides, 5th Edition** mandates that process. It was not done. SB 289 was enacted to stop the manipulation of the regulation by certain rating doctors and insurance companies. SB 289 now applies to this rating because the Appellant's claim has not been closed and since SB 289 clarifies, rather than substantively changes NRS 616C.490, the amendment has retroactive effect. Under SB 289, NRS 616C.490(2) governs the apportionment of the Appellant's PPD award. Further, confirming apportionment of 75% was a misapplication of the regulation and in violation of the statute, both as it existed in 2018 and as it exists now under SB 289. There was no prior rating for the cervical spine. There was no prior surgery of the cervical spine. There is no medical documentation or health care records of a preexisting whole person impairment for the Appellant's cervical spine. For these reasons, the percentage of present impairment cannot be reduced by any percentage for the pre-existing condition.

As stated in the Appellant's Opening Brief, under the prior language of NRS 616C.490 and NAC 616C.490, because there was no documentation of a prior cervical condition and a complete analysis demonstrating the scope and

nature of any impairment in her cervical spine existing prior to the Appellant's June 25, 2015 industrial injury as required by NAC 616C.490(6), no apportionment is permitted as a matter of law under NAC 616C.490(8).

The Petition for Judicial Review should have been granted, the matter reversed and remanded, and the Appellant awarded the 27% PPD found by Dr. Jempsa without apportionment.

WHEREFORE, the Petitioner respectfully asks that the Court **REVERSE** the District Court denial of the Appellant's Petition for Judicial Review, **REVERSE** the Appeals Officer's Decision and reinstate the Hearing Officer's Decision, instructing the Respondent to offer the Appellant the un-apportioned 27% PPD award pursuant to Dr. Jempsa.

RESPECTFULLY SUBMITTED this 1 day of April, 2022.

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ATTORNEY'S CERTIFICATION IN COMPLIANCE WITH RULE 28.2 OF THE NEVADA RULES OF APPELLATE PROCEDURE

Herb Santos, Jr., Attorney for Appellant, by signing below, hereby certifies in compliance with Rule 28.2 of the Nevada Rules of Appellate Procedure that:

1. I hereby certify that this reply brief complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type style requirements of NRAP 32(a)(6) because this reply brief has been prepared in a proportionally spaced typeface using Microsoft Word 365 in Times New Roman size 14 font;

2. I further certify that this reply brief complies with the page- or type-volume limitations of NRAP 32(a)(7) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(c), it is proportionately spaced, has a typeface of 14 points or more, and contains 6480 words;

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

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of the Nevada Rules of Appellate Procedure.

DATED this 1 day of April, 2022.

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AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby certify that the preceding document, ***APPELLANT'S REPLY BRIEF***, filed in Supreme Court case number 82608, does not contain the social security number of any person.

DATED this 1 day of April, 2022.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on April 1, 2022, I filed the foregoing Appellant's Reply Brief through the Supreme Court of Nevada's electronic filing system along with the Appellant's Appendix. Electronic service of the foregoing shall be made in accordance with the Master Service List as follows:

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and that on said date a copy of the same was deposited in the United States Mail with first class postage fully repaid addressed to the following:

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DATED this 1 day of April, 2022.

Jimayne Merkow