IN THE SUPREME COURT OF THE STATE OF NEVADA

WILLIAM POREMBA

Petitioner,

vs.

SOUTHERN NEVADA PAVING; S&C CLAIMS SERVICE and DEPARTMENT OF ADMINISTRATION, APPEALS OFFICER,

Respondent.

Case No.: 66888

APPENDIX

VOLUME VIII

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APPENDIX TO APPELLANT'S OPENING BRIEF

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DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM POREMBA, Petitioner, vs. SOUTHERN NEVADA PAVING; S&C CLAIMS SERVICES, INC.; AND NEVADA DEPARTMENT OF ADMINISTRATION, APPEALS OFFICER Respondents.	Case No.: A-14-698184-J Dept. No.: II

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

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NEVADA REVISED STATUTES

STATEMENT OF THE CASE

Petitioner, WILLIAM POREMBA (hereinafter, "Claimant" or "Petitioner"), filed a Petition for Judicial Review of an Appeal Officer's Order Granting Summary Judgment against him in a contested workers' compensation claim.

The Claimant appealed from the denial of reopening of his worker's compensation claim. There was no medical evidence submitted to supporting the reopening. (ROA 015 at 246).

By way of background, the Claimant was involved in a vehicle-heavy equipment accident on or about July 22, 2005 while at work. He sought medical treatment and filled out a C-4 three days later on July 25, 2005. He was diagnosed with thoracic, cervical strains; a face contusion and a knee contusion. (ROA 015, at 133).

A follow-up appointment at Concentra on July 29, 2005 produced the same diagnosis. (ROA 015, at 138).

Claimant treated on his own outside of worker's compensation arena on August 2, 2005. (ROA 015, at 140-141).

Claimant was informed by the Insurer that he could not treat with non-preferred providers and could only have one treating physician. (ROA 015, at 142-144). Care was transferred to Dr. Angela Thomas. (ROA 015, at 145).

On August 12, 2005, the claim was accepted for cervical strain, lumbar strain and left knee sprain. (ROA 015, at 149). The accepted scope of the claim was never appealed by the Claimant.

On August 12, 2005, Dr. Thomas documented that Claimant had a non-industrial history of chronic low back pain. (ROA 015, at 151). Physical therapy was recommended.

Claimant and his counsel were informed of the Insurer's lien in August 2005. (ROA 015, at 153). Several MRIs were performed.

Dr. Thomas recommended physical therapy.

On November 7, 2005, Dr. LaTourette opined that Claimant would need knee surgery in the future. (ROA 015, at 171-172).

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The Insurer sent a claim closure letter on January 27, 2006. (ROA 015, at 175). The claim closed.

On October 5, 2010, the Insurer sought recovery of its worker's compensation lien. (ROA 015, at 174).

On November 3, 2010, Claimant sought to reopen his claim, more than one year after it closed. Claimant provided a one-page letter from Sudir Khenika, M.D., which did not have any medical records attached. The letter asks for reopening since the Claimant has had increased pain complaints. This is the PRIOR request for reopening and not the one that is the subject of this appeal. (ROA 015, at 179).

On November 8, 2010, the Insurer denied reopening because the Claimant had not proven that he has exhausted his third-party recovery on medical treatment, which he must do before the Insurer would be responsible to pay for reopening and future medical treatment. (ROA 015, at 180).

In November 2010, Claimant returned to the Las Vegas Pain Institute for neck and low back pain. (ROA 015, at 182). He was told to continue home exercises. (ROA 015, at 184).

The Claimant received a settlement of $63,500.00 from a responsible third party who caused his accident. (ROA 015, at 188). According to the Claimant's affidavit, he personally received $34,631.51 in settlement proceeds. That money has been exhausted prior to this reopening request but it has not been proven to be exhausted on medical treatment that would otherwise be part of the worker's compensation claim. (ROA 015, at 188-189). Claimant admits that he used that money to support his family and pay household bills.

Claimant previously appealed the denial of reopening of his claim. On March 7, 2011, the Hearing Officer properly denied the request for reopening. (ROA 015, at 220-224).

Claimant appealed to the Appeals Office. (ROA 015, at 232).

On May 6, 2011, the Insurer filed a Motion for Summary Judgment regarding the appeal over the denial of reopening before a different Appeals Officer. (ROA 015, at 237-243).

On May 17, 2011, the Appeals Officer GRANTED the Insurer's prior Motion for Summary Judgment. (ROA 015, at 244-245).

Claimant waited approximately a year and on November 8, 2012, his counsel sought reopening once again. Again, there is no new medical reporting to support this request and again the Claimant has not proven that he has exhausted his third-party proceeds on medical treatment before asking the Insurer to pay for more benefits under the worker's compensation claim.

On November 8, 2012, the Insurer denied the request for reopening. (ROA 015, at 247).

The Claimant appealed and the parties agreed to bypass the Hearing Officer hearing.

The Insurer filed a Motion for Summary Judgment. It was opposed and Appeals Officer Shirley Lindsey denied the Motion. (ROA 010).

At the appeal hearing, the defense counsel again raised the Motion for Summary Judgment which the Judge denied. (ROA 003 at 22-23). A full hearing took place on the merits. The Claimant testified that he received $34,631.51 in settlement proceeds from his third-party lawsuit. (ROA 003 at 56).

The Claimant testified that he spent the $34,631.51 on some medical bills and he and his family lived off it; it paid for his house; it paid for his food. (ROA 003, at 33). Claimant admits that he spent the money on expenses required to support his two children, one in college and one in middle school. (ROA 003 at 50).

It is undisputed that the Claimant did not spend the entire $34,631.51 on medical expenses that would otherwise be part of his worker's compensation claim. (ROA 003, at 50).

In closing argument, the Claimant argued that he may spend the $34,631.51 in settlement proceeds he received from the third-party lawsuit on paying his mortgage and putting food on the table for his family. (ROA 003 at 55). The Claimant also argued that he "needs a home to live in to be able to recover. Particularly, he needs food and healthy diet to be able to recover" (Id.)

While all humans need food and shelter to stay alive, that is not the inquiry here. The issue before the Appeals Officer was whether the Claimant spent his third-party settlement

proceeds on medical treatment that would otherwise be the responsibility of the insurance company if his worker's compensation claim were to be reopened. It is undisputed that the money was spent on other things, such as paying his mortgage, on his family and on his own food and shelter needs. The Claimant admits that he did not spend the $34,631.51 on medical care that would be the responsibility of the worker's compensation Insurer if the claim was reopened.

The Insurer made two arguments in closing: (1) that the Claimant has not proven that he has exhausted his offset because he has not proven that he spent his third-party proceeds on medical care incurred after the date of settlement; and (2) even if we could reach the issue of reopening, the Claimant has insufficient medical evidence to prove the need for more treatment on al basis. (ROA 003 at 56-62). The medical records used to support reopening were nd had previously been rejected in a prior attempt to reopen. (ROA 003 at 61-62). o new medical reports since the last denial of reopening was made. The medical g relied upon are from 2009 and 2010.

Subsequently, Appeals Officer Shirley Lindsey issued an Order Granting the otion for Summary Judgment. (ROA 004). The Appeals Officer issued the Order in ng a Decision and Order with Findings of Fact and Conclusions of Law.

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

The Claimant filed a Petition for Judicial Review and an Opening Brief.

This Answering Brief follows.

II.

STATEMENT OF ISSUES

(1) Whether Petitioner has established that the ruling of the Appeals Officer, filed on February 25, 2014, is clearly erroneous in view of the reliable, probative and substantial evidence on the whole record or is arbitrary or capricious.

(2) Whether the Appeals Officer was correct in finding that claim reopening was not warranted at this time.

III.

STATEMENT OF THE FACTS

This is the Claimant's Petition for Judicial Review of an Order Granting the Insurer's Motion for Summary Judgment in a contested workers' compensation case.

The Insurer believes that the Order issued by the Appeals Officer is correct. Even if this Court believes that the Appeals Officer could have issued a Decision and Order instead of an Order Granting Summary Judgment, the outcome is the same and it is supported by all of the evidence in the record on appeal.

The Respondent's assert that the Appeals Officer erroneously denied the Motion for Summary Judgment when it was filed months before the appeal hearing.

As a result of that ruling, a full hearing took place on the merits on January 29, 2104. The Claimant appeared and testified under oath. It was clear to all parties that the Insurer's counsel was still arguing that the Claimant failed to prove that he properly exhausted his third-party proceeds to effectuate an offset and that medical evidence failed to support reopening. Candidly, the Insurer has been making this argument for years (it was the same argument that prevailed in stopping reopening in 2011). (ROA 003, at 22-23 and 56).

The Insurer argued that the Claimant had attempted to reopen his worker's compensation claim once before unsuccessfully. A different Appeals Officer granted the Insurer's Motion for Summary Judgment when the Claimant tried to reopen his workers' compensation claim in 2011. (ROA 015 at 244-245). Thus, it was argued that any evidence to support the current request for reopening would need to be based on new medical evidence obtained since 2011. However, there is no new evidence. The Claimant is still relying on the 2009 and 2010 medical reports which were deemed insufficient in 2011 and remain insufficient now. (ROA 003, at 61-62).

The Claimant argued that he could use his settlement proceeds on whatever he wanted and that his medical records show that he needs more treatment so his claim should be reopened. (ROA 003 at 55).

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Once the appeals hearing concluded, the parties both expected the Appeals Officer to issue a "Decision and Order" with Findings of Fact and Conclusions of Law.

Instead, the Appeals Officer issued an Order Granting Summary Judgment in favor of the Insurer. Regardless of the form, the ruling that reopening was properly denied is correct. The Appeals Officer is the trier of fact and a Petition for Judicial Review is not a de novo hearing.

IV.

JURISDICTION

A. STANDARD OF REVIEW

The parameters of judicial review are established by statute. Judicial review of a final decision of an agency must be conducted by the court without a jury and confined to the record as provided by NRS 233B.135(1). The final decision of the agency shall be deemed reasonable and lawful until that decision is reversed or set aside in whole or in part by the court. NRS 233B.135(2). The burden of the proof is on the party attacking the decision to show the final decision is invalid. NRS 233B.135(2)(3).

B. THIS COURT MAY NOT SET ASIDE A DECISION UNLESS IT IS CLEARLY ERRONEOUS

A court may set aside, in whole or in part, a final decision of an administrative agency where substantial rights of the Petitioner have been prejudiced because the final decision is in violation of statutory provisions, affected by other error of law, clearly erroneous in view of the reliable, probative and substantial evidence on the whole record, or arbitrary, capricious or characterized by abuse of discretion. NRS 233B.135(3).

The Order by the Appeals Officer complies with the statutory provisions as it is based upon the reliable, probative and substantial evidence on the whole record and does not contain an error of law.

The Supreme Court has clearly held that a reviewing court may set aside an agency decision only if the decision was based upon an incorrect conclusion of law or otherwise affected by an error of law. State Indus. Ins. Sys. v. Giles, 110 Nev. 216, 871 P.2d 920 (1994); Jessop v. State Indus. Ins. Sys., 107 Nev. 888, 822 P.2d 116 (1991). Further, the Supreme Court has stated

that an appellate review on a question of law is de novo, and that the reviewing court is free to address purely legal questions without deference to the decision. Giles, *supra*; Mirage v. State, Dep't of Admin., 110 Nev. 257, 871 P.2d 317 (1994); American Int'l Vacations v. MacBride, 99 Nev. 324, 326, 661 P.2d 1301, 1302 (1983); see, also, State Dep't of Motor Vehicles v. Torres, 105 Nev. 558, 560, 799 P.2d 959, 960 961 (1989).

The Petition for Judicial Review must be denied as the Appeal Officer's Order is supported by substantial evidence. The Order is based on substantial evidence contained in the whole record that is undisputed.

V.

ARGUMENT

A. PETITIONER HAS NOT ESTABLISHED AN ERROR OF LAW.

As outlined above, there is no error of law here committed by the Appeals Officer.

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

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

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The arguments the Petitioner appears to be making now were already made to the Appeals Officer through his counsel before he lost the appeal hearing. There is nothing new here, just an attempt to get another bite at the proverbial "apple" since the Appeals Officer did not agree with the Claimant's arguments. That is insufficient to warrant the granting of a Petition for Judicial Review.

B. THE ORDER IS SUPPORTED BY SUBSTANTIAL AND PERSUASIVE EVIDENCE

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

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

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

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

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

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

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

(Emphasis added).

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

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

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

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

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

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

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

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

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

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

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

Claimant wants to be paid benefits under his workers' compensation claim when he did not use the $34,631.51 on benefits that would be covered under his workers' compensation claim. Obviously, if an individual is provided with medical care under a worker's compensation

claim, that individual is not going to pay the same doctor for the bills paid under the worker's compensation claim. That would be double payment.

Double recovery is when an individual is provided money for the accident benefits and then asks that the same accident benefits be paid under the worker's compensation claim (i.e. the worker gets the money for the accident benefits and asks the worker's compensation carrier to pay for the accident benefits – double recovery). That is exactly what the Claimant is asking this Court to order and exactly what every Court mentioned above has rejected.

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

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

Furthermore, even assuming arguendo that the merits of the reopening could be reached, the Claimant has not met his burden of proof to prove reopening. He has a letter from his counsel and some old doctor letters from 2009 and 2010. The letter from counsel purports of subjective complaints of pain. This falls well below the Claimant's legal burden of proof.

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

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

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

Additionally, we must remember the procedural posture in this case, as it is telling. This Claimant previously appealed the denial of reopening of his claim in 2011. On March 7, 2011, the Hearing Officer properly denied the request for reopening. (ROA 015 at 220-224).

The Claimant appealed and lost. The present appeal is based on the same old medical evidence that was insufficient in the last attempt to reopen. **On May 17, 2011, the prior Appeals Officer GRANTED the Insurer's Motion for Summary Judgment.** (ROA 015 at 244-245).

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

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

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

The Petitioner is asking this court to re-weigh the facts, which may not be done now. The Appeals Officer applied all the laws correctly. Therefore, the facts and the law support the denial of Petitioner's Petition for Judicial Review.

VI.

CONCLUSION

The Petitioner has not met the difficult and high burden which must be met in order to obtain the granting of a petition for judicial review. No error of law has been proven, and the evidence may not be re-weighed. The ruling of the Appeals Officer is supported by undisputed credible and substantial evidence. The ruling is also supported by binding case law.

The Appeals Officer evaluated the Record as a whole and concluded that a preponderance of the evidence in the Record supported the denial of reopening. Therefore, it is respectfully requested that the Petition for Judicial Review be denied.

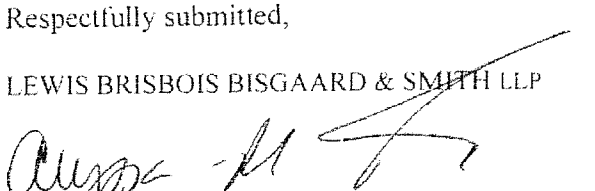
Even if this Court were to remand the matter back to the Appeals Officer to expressly make Findings of Fact and Conclusions of Law, it is clear that she still would not rule in favor of the Claimant, so there would be another Petition for Judicial Review and we would be right back where we are now.

Claimant had his day in court. His arguments were new and creative, but they are inconsistent with the law and were properly rejected by the Appeals Officer. The totality of the evidence supports the denial of the Petition for Judicial Review. The Insurer seeks an Order for the same.

DATED this 21st day of July, 2014.

Respectfully submitted,

LEWIS BRISBOIS BISGAARD & SMITH LLP



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CERTIFICATE OF COMPLIANCE

I hereby certify that I have read this appellate brief and, to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e), 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 21st day of July, 2014.

Respectfully submitted,

LEWIS BRISBOIS BISGAARD & SMITH LLP

By _____

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CERTIFICATE OF MAILING

Pursuant to Nevada Rules of Civil Procedure 5(b), I hereby certify that, on the 21st day of July, 2014, service of the **RESPONDENTS S&C CLAIMS SERVICES, INC., AND SOUTHERN NEVADA PAVING'S ANSWERING BRIEFANSWERING BRIEF** was made this date by depositing a true copy of the same for mailing, first class mail, at Las Vegas, Nevada, addressed follows:

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An employee of LEWIS BRISBOIS BISGAARD & SMITH, LLP

AFFIRMATION
Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding Respondents' Answering Brief in Case No. A-14-698184-J:

☒ Does not contain the Social Security number of any person.

- OR -

☐ Contains the Social Security number of a person as required by:

A. A specific state or federal law, to wit:

(State specific law.)

- or -

B. For the administration of a public program or for an application for a federal or state grant.

Alyssa M. Fischer, Esq.
Attorneys for Respondents
S&C CLAIMS SERVICES, INC., and
SOUTHERN NEVADA PAVING

7-21-14
Date

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DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM POREMBA Petitioner, vs. SOUTHERN NEVADA PAVING; S&C CLAIMS SERVICE and DEPARTMENT OF ADMINISTRATION, APPEALS OFFICER, Respondent.	CASE NO. : A-14-698184 DEPT NO. : II

PETITIONERS REPLY BRIEF

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ARGUMENT

A. Introduction

On-the-job injuries not only cost workers the need for medical treatment but also the wages that they need for the costs of daily living. That is why Nevada's workers compensation laws not only provide injured workers access to medical care but also accommodates for lost wages—wages that are used for mortgages, food, and bills. This lost wage compensation due to work injury is a benefit afforded under Nevada's workers compensation statutes (injured employees unable to work for at least five consecutive days or five cumulative days within a 20 day period may be entitled to monthly compensation for lost wages). *See,* NRS 616C.400; NRS 616C.440(1)(a); and NRS 616C.490(7). If a medical provider's report indicates that an employee cannot work because of a covered work injury then the employee may receive disability payments, *see*, NRS 616C.490, and/or reopen a claim to receive additional medical care and/or disability payments, *see*, NRS 616C.390. To determine the extent of the disability for compensation purposes a rating physician must evaluate the injured worker. See, NRS 616C.475(5); and NRS 616C.490(2). The benefit of lost wage compensation shows that Nevada workers compensation laws provide a benefit to pay for living expenses after being injured and not just merely having access to medical care, both are important.

B. Petitioner does have new medical reporting and has met all the elements of reopening outlined in the statute.

Respondent mistakenly believes that the Petitioner is relying solely on Dr. Khanka's 2010 report/letter and incorrectly states that there is no new medical reporting to support his request for reopening. Respondents Answering Brief p. 3:1 and p. 13:5. However, Petitioner clearly has additional medical reporting to satisfy the statutory elements of reopening a workers compensation claim. Petitioner has pointed and cited to a second doctors report/letter from Dr. Jeremy Lipshutz

from Monos Health Institute in both his opening brief to this Court, p. 10-11, and his appeals memorandum to the Department of Administration, supp ROA 006, p. 84-86. And Dr. Lipshutz' doctors report/letter dated January 21, 2014, supp ROA 019, p. 301-302, by itself is enough to meet the minimum statutory reopening requirements of NRS 616C.390, which outlines the following elements (emphasis added):

> 1. If an application to reopen a claim to increase or rearrange compensation is made in writing more than 1 year after the date on which the claim was closed, the insurer **shall reopen** the claim **if:**
>
> (a) A ***change of circumstances*** warrants an increase or rearrangement of compensation during the life of the claimant;
>
> (b) The ***primary cause*** of the change of circumstances ***is the injury*** for which the claim was originally made; and
>
> (c) The application is ***accompanied by the certificate of a physician*** or a chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation.

Here, when we compare Dr. Lipshutz report/letter we can see that this year a doctor did provide new medical reporting establishing all the elements for reopening , outlined below (Dr. Lipshutz direct quotes followed in parentheses):

1. Petitioner's condition has ***changed*** since claim closure ("His pain has worsened over the last two years").
2. Petitioner ***needs treatment*** ("He will need new cervical, thoracic and lumbar imaging to determine the extent of his physical incapacity as well as…nerve conduction study with electromyography").
3. A ***description of the treatment*** ("Cervical and lumbar medial branch blocks are warranted at this time as well as initiation of physical therapy 3x weekly for 12 weeks").
4. That there is a ***direct relationship*** Petitioner's worsened condition at the time he asked for reopening and his original injury ("These new symptoms are directly attributable to his 2005 work injury").

///

5. Petitioner's work injury is the ***primary cause*** for his need to reopen his claim ("William Poremba who has been a patient for several years following an accident which occurred at his workplace...resulting in neck, left leg/knee and low back pain...[h]is pain has worsened...and has not been addressed").

6. Any ***specified time period*** Petitioner is not to work at his job ("Mr. Poremba is currently unable to work in any capacity").

Simply, despite Respondent's claims otherwise, Petitioner does have new medical reporting; and further it meets all the elements of reopening outlined in the statute. And even though it has already been cited to and is in the record, Petitioner, for ease and clarity, will attach Dr. Lipshutz' one page report/letter, located with Dr. Khanka's report/letter in sup ROA 019, p. 301-302, as Exhibit 1.

C. EICON is narrower than Respondent argues it to be, did not abrogate injured workers statutory rights to reopen their workers compensation claim, is distinguishable from this case, and allows for exhaustion of third party funds on items other than medical expenses.

Beyond Petitioners argument regarding the interpretation of *Employers Ins. Co. of Nevada v. Chandler*, 23 P.3d 255 (Nev. 2001)("EICON") in his opening brief, Petitioner believes a careful reading EICON also shows that Respondents interpretation of the case law is at odds with the mandatory language found in NRS 616C.390 by trying to add an element of exhaustion to the statutory reopening requirements. EICON is not a case that abrogated the reopening statute or any workers compensation statute but merely defined what the term "compensation" in those statutes included. Simply, EICON did not remove the term "shall" from NRS 616C.390, which means Petitioner, when he fulfilled the requirements of NRS 616C.390, was entitled to reopening his workers compensation claim and Respondent was mandated to allow it.

Moreover, this case is distinguishable from EICON. In EICON, the injured worker still had their third party funds available to them (**not exhausted**). While here in this case Petitioner no longer has third party funds available to him (**exhausted**). In comparing the two cases there is a

direct opposing distinction (not exhausted vs. exhausted). Meaning the fact patterns are fundamentally different and alters how EICON applies to the Petitioner, so, how EICON is applied to Petitioner's fact pattern must be different than Respondent argues for. Related, EICON did not provide analysis or dicta regarding situations when third party funds are exhausted or how it affects other benefits like lost wages.

In connection to the argument in the previous sentence, NRS 616A.090 defines "compensation" to include "accident benefits," benefits which includes ***lost wages*** by the injured employee. NRS 616C.400; 616C.440(1)(a); and NRS 616C.490(7). So it is entirely possible to interpret EICON as follows: "We conclude that an insurer is entitled to withhold payment of [benefits] for a work-related injury until an employee has exhausted any third-party settlement proceeds because the plain meaning of the term "compensation" in NRS 616C.215 includes [lost wages]," *see generally* EICON at 258; NRS 616C.400; 616C.440(1)(a); and NRS 616C.490(7). And because lost wages can be used for other items other than medical costs, such as, mortgages or food, it would be entirely permissible to exhaust third party funds on these other items; items that would have been paid for using lost wage compensation paid out by Respondent to Petitioner.

D. Respondent is incorrectly arguing for the denial of reopening, rather than for the withholding of payment found in EICON or reimbursement found in NRS 616C.215.

It appears from Respondent's answering brief that it is arguing for the denial of reopening Petitioner's claim. And in Respondent's argument it cites to EICON, NRS 616C.215, and non-authoritative case law. However, in EICON the holding only "entitled to *withhold* payment of medical benefits for a work-related injury *until* an employee has exhausted any third-party settlement proceeds, not denial of reopening. EICON at 258 (emphasis added) (noting there is no phrase "solely on medical treatment" qualifying the word "exhausted").

///

Next, in NRS 616C.215 we find the following (emphasis added):

> (1)(a) The injured employee, or in case of death the dependents of the employee, may take proceedings against that person to recover damages, but the amount of the compensation the injured employee or the dependents of the employee are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, **including any future compensation, must be reduced by the amount of the damages recovered,** notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

This statutory provision does not exclude injured workers from reopening, it merely requires any compensation provided to the injured worker through the workers compensation statute to be *reduced*, not denied—or even withheld. It also accounts for reductions to be applied to *future* compensation. For example, here, Petitioner received around $34,000 from third party settlement funds (this is not considering the $14,000 spent on medical treatment by Petitioner with these proceeds). And if we applied these numbers to possible future compensation (determined by statutory calculations based upon a physician's rating when reopened) that say for example totals $60,000, then Respondent would be allowed to reduce the $60,000 "compensation" owed to Petitioner by $34,000 and merely pays out $26,000; leaving Petitioner to ultimately receive his compensation of $60,000 while Respondent only pays $26,000 of it. Meaning, Petitioner does not take a double recovery and Respondent pays less than it would have. If anything, based on future reduction, Petitioners third party recovery saved Respondent from paying out a larger compensation under the workers compensation statutes had Petitioner not opted to seek liability from a third party. In other words based on future reduction provided for in NRS 616C.215, Respondent, no matter the outcome, will always have a savings of at least $34,000 and Petitioner will never take a double recovery.

Lastly, Respondent's citations to non-authoritative case law from other states show more the principal or idea of reduction similar to NRS 616.215 and generally not the argument of denying reopening a workers compensation claim.

CONCLUSION

Petitioner by matter of statutory right is permitted to reopen his workers compensation claim at this time and Respondent by the same statute is mandated to reopen Petitioner's claim. The Petitioner has complied with the elements of the reopening statute based on new medical reporting and any arguments offered by the Respondent in an attempt to avoid reopening Petitioner's claim does not fit in harmony with the case law and statutes cited. The case law is narrower than Respondent argues it to be, has not abrogate injured workers statutory rights to reopen their workers compensation claim, is distinguishable from this case, and allows for exhaustion of third party funds on items other than medical expenses. Simply the Respondent is incorrect in arguing for the denial of reopening, rather than for the future reimbursement provision found in NRS 616C.215. And any reliance by the Divisions appeals officer by any of Respondent's arguments to support her decision is equally incorrect. Therefore, Petitioner should be awarded his statutory right to reopen his workers compensation claim.

DATED this 26 day of August, 2014.

DUNKLEY LAW

By: _____

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CERTIFICATE OF COMPLIANCE

I hereby certify that I have read this appellate brief and, to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e), 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 25 day of August, 2014.

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CERTIFICATE OF MAILING

I certify that on this 25th day of August, 2014, the foregoing PETITIONERS REPLY BRIEF was served on the following by depositing a true copy of the same for mailing, first class mail addressed as follows:

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Department of Administration
Hearings Division-Appeals Office
Appeals Officer Shirley D. Lindsey, Esq.
2200 South Rancho Drive, Suite 220
Las Vegas, Nevada 89102

An Employee of Dunkley Law

EXHIBIT 1

MONOS HEALTH INSTITUTE
PAIN MANAGEMENT AND ADDICTION MEDICINE
Jeremy M. Lipshutz, M.D., M.H.S. • Heath Wills, M.D.

January 21, 2014

Re: William Poremba 06/30/1964

Dear Sir or Maddam:

This letter is in regards to William Poremba who has been my patient for several years following an accident which occurred at his workplace. The accident occurred July 22, 2005 resulting in neck, left leg/knee and low back pain. He has undergone left knee arthroscopy for meniscus repair as well as a cervical spine fusion. His pain has worsened over the last two years and his low back pain has not been addressed. Mr. Poremba reports pain now involving the thoracic region as well as a bilateral upper extremity and hand weakness. He has difficulty holding a full cup and cannot exercise without severe pain. Most of his activities of daily living require modifications or help to complete. These new symptoms are directly attributable to his 2005 work injury.

Due to his worsening symptoms, Mr. Poremba is currently unable to work in any capacity. He will need new cervical, thoracic and lumbar imaging to determine the extent of his physical incapacity as well as a bilateral upper extremity nerve conduction study with electromyography (please see prior imaging reports revealing steady worsening of his spinal degeneration). Cervical and lumbar bilateral medial branch blocks are warranted at this time as well as initiation of physical therapy 3 x weekly for 12 weeks.

If you have any questions or require further information regarding Mr. Poremba's worsening condition, please do not hesitate to contact me.

Sincerely,

Jeremy Lipshutz M.D.

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DISTRICT COURT

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REQUEST FOR HEARING

TO: Southern Nevada Paving; S&C Claims Service; The State of Nevada Department of Administration, Appeals Division, Appeals Office and Appeals Officer.

TO: Alyssa M. Fischer, Esq.

PLEASE TAKE NOTICE that the undersigned has requested a hearing on the above referenced Petition for Judicial Review, pursuant to NRS 233B.133(4).

///

///

This hearing will be held before the above entitled Court on the 29 day of Sept, 2014 In Chambers
~~2013~~, at _____, a.m./p.m. in the above department, or as soon thereafter as counsel can be heard.

DATED this 20 day of August, 2014.

DUNKLEY LAW

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