IN THE SUPREME COURT OF THE STATE OF NEVADA

WILLIAM POREMBA Appellant, vs. SOUTHERN NEVADA PAVING; S&C CLAIMS SERVICE and DEPARTMENT OF ADMINISTRATION, APPEALS OFFICER, Respondent.	**Supreme Court No. 66888** Dist. Ct. Case No. A-698184

APPELLANT'S OPENING BRIEF

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I.

STATEMENT OF THE CASE

A. Introduction

This case is a workers compensation case. Appellant is William Poremba, an injured worker and Respondent is S&C Claims Services, an insurer, on behalf of Southern Nevada Paving, an employer. In this case Poremba also received third-party compensation from a work related accident. Poremba's workers compensation claim is closed and his third-party funds have been exhausted. Poremba exhausted his funds on both medical and living expenses. Poremba's medical condition related to his work-accident has worsened and has been confirmed by his doctors. Poremba has lifetime reopening rights and is trying to reopen his workers compensation claim. However, Poremba's attempts to reopen his workers compensation claim pursuant to NRS 613C.390 have been denied based on what he believes to be incorrect reading and application of case law abrogating statutory provisions.

B. Course of Proceedings

Appellant Poremba suffered injuries at work from an accident caused by a third-party on July 22, 2005. (Appellant Appendix, hereinafter "APP" at p. 22). A workers compensation claim was accepted for these injuries. (APP p.

37). Additional to opening a workers compensation claim, a lawsuit was filed against the third-party. (APP p. 62). Thereafter, Poremba's workers compensation claim was closed. (APP p. 60) And Poremba subsequently settled his claims with the third-party. (APP p. 152).

On November 3, 2010 Poremba sought to reopen his workers compensation claim but reopening was ultimately denied by summary judgment. (APP 124-132). More than a year later Poremba again sought to reopen his workers compensation claim bypassing the hearing officer by stipulation. (APP p. 1-3) Respondent then filed a motion for summary judgment (APP p. 6) which was denied by the Appeals Officer, Shirley D. Lindsey, Esq., (APP p. 191). A motion for summary judgment was not re-raised at any point after. Poremba further supported his request to reopen his workers compensation with a new doctor's letter conforming to NRS 616C.390. (APP 227). A hearing on the matter was heard on January 29, 2014. (APP p. 300-360). And then on February 25, 2014 Officer Lindsey retroactively granted Respondent's motion for summary judgment. (APP p. 298). Officer Lindsey did not provide any statements of fact or conclusions of law.

On March 25, 2014 Poremba petitioned the District Court for judicial review. (APP p. 362-367). And after briefs were filed with the District Court, Poremba requested a hearing. (426-427). However, the District Court's decision

was made in chambers, the attorneys for the parties were not present, no oral arguments were made, and no transcript was made.(APP p. 430-433).

II.

STATEMENT OF THE ISSUES

The nature of the action includes statutory interpretation[1] of Nevada workers compensation laws to answer the following issues:

1. Whether a decision by an appeals officer to retroactively grant an already dismissed motion for summary judgment without being re-raised fails to meet the notice requirements of NRS 233B.121 making the decision procedurally improper. And whether a final order by an appeals officer granting summary judgment without any written findings of fact or conclusions of law makes the order procedurally deficient.

2. As a matter of law can a failure to exhaust third party settlement funds be used to preclude reopening a workers compensation claim when the worker has met the statutory requirements to reopen his claim pursuant to NRS 613C.390, or does it merely allow withholding or offsets?

    a. And if so, as a matter of law must a claimant exhaust third party settlement funds solely on medical costs before he can reopen his workers compensation claim, or may the funds be exhausted on other needs?

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[1] Beyond interpreting NRS 613C.390, this appeal will involve interpretation of case law, *Employers Ins. Co. of Nevada v. Chandler*, 23 P.3d 255 (Nev. 2001), and its relationship to NRS 613C.390.

III.

STATEMENT OF THE FACTS

This case stems from a motor vehicle accident that occurred on July 22, 2005. (APP p. 22). At the time of the accident, Appellant, William Poremba, was working for Southern Nevada Paving and driving a tractor trailer dump truck. *Id.* On the same day an employee of Pratte Development Company was driving a backhoe near the same jobsite. *Id.* As Poremba was driving his truck on a paved road in a neighborhood that was under development, the Pratte backhoe ran a stop sign hitting the driver's side of Poremba's truck. *Id.*

Originally, Poremba made a worker's compensation claim for injuries to his neck, back, and left knee. Id. The workers compensation claim was accepted for these body parts, but was closed in January 2006. (APP p. 37 and 60). However, before closure of the workers compensation claim, it was made known that Poremba would need knee surgery in the future. (APP p. 57).

Additional to opening a workers compensation claim, a lawsuit was filed against Pratte Development Company and Poremba also sustained costs for medical treatment outside the workers compensation network for the same injuries. (APP p. 152). The lawsuit settled on July 30, 2009 for $63,500 and the medical bills contemplated as part of the settlement totaled $77,064.30. *Id.* Poremba personally ended up netting $34,631.51 after final distributions were

made. (APP p. 183).

Since the settlement, Poremba has had continuous medical treatment for his work related injuries in this case. (APP p. 351). Since receiving the settlement, Poremba has spent approximately $14,000.00 for medical insurance payments, prescriptions, and co-pays in medical expenses for injuries relating to his accident (APP p. 183). The medical bills incurred have exceeded the total net he received of $34,631.51 and Poremba currently has approximately over $20,000 in unpaid medical bills. *Id.*

Since the accident, Poremba has not been able to work due to the injuries he suffered in the subject accident. *Id.* He tried to go back to work but had to quit due to pain in his cervical spine and was told by his doctor not to go back to work. *Id.* And since his settlement, Poremba has averaged an income of slightly more than $5,000. *Id.* However, Poremba's costs of living have far exceeded his meager income and drained his finances, including exhausting his settlement money in less than a year. *Id.*

On November 3, 2010 Poremba sought to reopen his workers compensation claim supported by a letter from Sudir Khemka MD but reopening was denied. (APP p. 64 and 124-132). Mr. Poremba then waited over a year and again sought reopening his workers compensation claim but the Respondent denied the request for reopening, so, Poremba appealed and

stipulated with Respondent to bypass the hearing officer. (APP p. 1-3). Respondent then filed a motion for summary judgment which was denied by the Appeals Officer, Shirley D. Lindsey, Esq., (APP p. 6). A motion for summary judgment was not re-raised at any point after. After the Respondent's motion for summary judgment was denied both the Respondent and Appellant filed appeal memorandums. (APP p. 193-200 and 217-223). Appellant in his appeal memorandum further supported his request to reopen his workers compensation with a second doctor's, Dr. Jeremy Lipshutz, recommendation that Poremba's workers compensation claim be reopened. (APP p. 217).

Dr. Lipshutz' letter (APP p. 217) stated the following about Poremba:

1. "His pain has worsened over the last two years;"

2. "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. "Cervical and lumbar medial branch blocks are warranted at this time as well as initiation of physical therapy 3x weekly for 12 weeks;"

4. "These new symptoms are directly attributable to his 2005 work injury;"

5. "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;" and

6. "Mr. Poremba is currently unable to work in any capacity."

IV.

STANDARD OF REVIEW

An administrative appeals officer's factual findings are reviewed for clear error or an arbitrary abuse of discretion and will only be overturned if those findings are not supported by substantial evidence. *See Elizondo v. Hood Mach., Inc.*, 312 P.3d 479, 482, (Nev. 2013) (internal citations omitted). Substantial evidence exists where a reasonable person can find adequate evidence in the record to support the appeals officer's decision. *Id.* The reviewing court's examination is limited to the record that was before the appeals officer, meaning the weight of the evidence going to questions of fact will not be disturbed by the reviewing court's judgment. *See Manwill v. Clark County*, 123 Nev. 28, 162 P.3d 876, 879 (Nev. 207). However, the reviewing court does independently review purely legal determinations made by the appeals officer. *Id.* Statutory construction is a question of law which invites independent appellate review of an administrative decision, *SITS v. Bokehnan*, 113 Nev. 1116, 946 P.2d 179 (1997), and is reviewed de novo, *Construction Indus. v. Chalue*, 119 Nev. 348, 74 P.3d 595 (2003). When a statute is clear and unambiguous, the plain and ordinary meaning of the words is given effect. *Cromer v. Wilson*, 126 Nev. 225 P.3d 788, 790 (2010). And statutory provisions are read as a whole, with effect given to each word and phrase. *Arguello v. Sunset Station, Inc.*, 127 Nev. 252 P.3d 206, 209 (2011).

Where there is no ambiguity, a resort to other sources, such as legislative history, in ascertaining that statute's meaning is improper. *See Cromer* at 790. Although a court's duty is to interpret statutory language it may not abrogate the legislatures function by expand or modifying the statutory language. *Washoe Med. Ctr., Inc. v. Reliance Ins. Co.*, 112 Nev. 494, 498, 915 P.2d 288, 290 (1996); see also *Williams v. United Parcel Servs.*, 129 Nev., 302 P.3d 1144, 1147 (2013) (refusing to deviate from the plain meaning of a statute and rejecting arguments that would require reading additional language into a statute).

V.

ARGUMENT

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.

A. The Appeals Officer's Order granting the Respondent's summary judgment was procedurally improper when no motion for summary judgment was pending and fails to meet the requirements of NRS 233B.125 by not offering findings of fact and conclusions of law.

In response to the Respondent's motion for summary judgment submitted March 26, 2013 the Appeals Officer issued an order on April 17, 2013 denying summary judgment. A motion for summary judgment was never raised again. However on February 25, 2014, after considering the briefing of both parties and conducting a scheduled hearing regarding the Appellant's contested claim, the Appeals Officer apparently took it upon herself to resurrect the Respondent's already denied motion and retroactively granted summary judgment in favor of the Respondent. The order granting Respondent's motion for summary judgment lacked any findings of fact and conclusions of law. The order simply states, "[a]fter careful

review and consideration of the Insurer's Motion for the summary Judgment and good cause appearing, IT IS HEREBY ORDERED that the Insurer's Motion for Summary Judgment is Granted." (APP p. 298).

It was procedurally improper for the Appeals Officer to revive the Respondent's judgment without any request to do so and particularly without notice to the Appellant. Moreover, by failing to provide the bases for denying the Appellant the right to reopen his workers compensation claim, the Appeals Officer committed an error of law warranting the set aside of the issued order.

The Nevada Administrative Procedure Act establishes minimum procedural requirements for adjudications with the Department of Administration's Hearing Division. NRS 233B.020. Within the Act the legislature requires notice of the nature of the hearing. NRS 233B.121 ("In a contested case, all parties must be afforded an opportunity for hearing after reasonable notice...The notice must include: A statement of the time, place and *nature* of the hearing") (emphasis added).

In this case, Appellant was not on notice that the attended hearing on January 29, 2014 was to decide a motion for summary judgment. The Respondent's motion for summary judgment had already been denied. Had Appellant known the hearing was supposed to be one to hear oral arguments regarding summary judgment he might have fashioned his argument differently. Because Appellant was not on notice of the nature of the hearing being one for summary judgment it was procedurally

improper and unfairly detrimental to the Appellant for the Appeals Officer to dispose of the contested claim by granting an already dismissed motion for summary judgment.

Furthermore, additional requirements concerning the procedural deficiencies of the Appeals Officer's decision and order can be found in NRS 233B.125, which states that a final decision must be in writing and include findings of fact and conclusions of law, separately stated. And these findings must be accompanied by a concise and explicit statement of the underlying facts supporting the findings. *Id.* Importantly, not only do factual findings help ensure that the appeals officer engages in reasoned decision making, but they also facilitate judicial review. *Dickinson v. Am. Med. Response*, 124 Nev. 460, 469, 186 P.3d 878, 884 (2008).

Here, none of these requirements were met by the final decision by the Appeals Officer when she dismissed the Appellant's appeal. As a consequence, because the Appeals Officer's Order is deficient, it precludes this Court from conducting an adequate review on appeal and prevents a determination of whether Appellant's substantial rights were violated.

B. Appellant has exhausted his third party settlement funds as required by statutory interpretation of NRS 616C.215(2)(a) and analyzed in *Employers Ins. Co. of Nevada v. Chandler*.

Although the Appeals Officer did not provide reasoning via findings of facts and conclusions of law to support her decision of granting the Respondent's motion

for summary judgment it must be assumed that the decision was based on the Respondent's arguments outlined in its motion for summary judgment. In its motion for summary judgment Respondent argued that the case of *Employers Ins. Co. of Nevada v. Chandler*, 23 P.3d 255 (Nev. 2001) ("EICON") supports the proposition that a claimant must exhaust third party settlement funds solely on medical care and treatment before the insurer is responsible for reopening the case. (APP p. 9-10). However, Appellant responded to this argument in his appeals memorandum (APP p. 219-222) and at the January 29, 2014 hearing (APP p. 300-360).

The interpretation of the holding in EICON raised by Respondent is a legal question and Appellant does not accept the Respondents interpretation. Appellant believes the Respondent is reading limitations into the term "compensation" that do not exist. *EICON* is case law interpreting the term "compensation" in workers compensation statutes—particularly NRS 616C.215(2)(a)—to include medical benefits. *EICON v. Chandler; see also Valdez v. Employers Ins. Co. of Nevada*, 162 P.3d 148, 123 Nev. 21 (Nev. 2007). The definition provided to the term "compensation" in

EICON *broadened* the term—not limited it—to *include* medical benefits, i.e., the addition of medical benefits to the term "compensation" was not all inclusive. *See generally, EICON.* Meaning the ten-n "compensation" can be achieved in a variety of permissible ways that do not necessarily include medical benefits—but can.

Furthermore, *EICON* only indicates that claimant would have to exhaust any third-party settlement proceeds, but it does not direct how or when. *See, id* at 258. So, the argument that Poremba has to show that he spent all his third-party settlement solely on medical treatment after he got it, reads solitary requirements into the statute and case law that do not exist. Poremba need only show that his settlement funds have indeed been exhausted—as they have been.

1. ***EICON* is narrower than Respondent has argued 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 Appellant's argument regarding the interpretation of *EICON*, Appellant believes a careful reading of *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 Poremba, 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 Poremba 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 Appellant, so, how *EICON* is applied to Appellant'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 Appellant.

2. Arguments to deny statutory reopening, rather than for the withholding of payment found in *EICON* or reimbursement found in NRS 616C.215, based on these citations are erroneous.

Respondents argue for the denial of reopening Appellant's claim. And in Respondent's argument it cites to *EICON*, NRS 616C.215, and non-authoritative case law. (*E.g.* APP p. 402-408 (Respondents Answering Brief to Petition for Review)). 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, Appellant received around $34,000 from third party settlement funds (this is not considering the $14,000 spent on medical treatment by Appellant 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 Appellant by $34,000 and merely pays out $26,000; leaving Appellant to ultimately receive his compensation of $60,000 while Respondent only pays $26,000 of it. Meaning, Appellant does not take a double recovery and Respondent pays less than it would have. If anything, based on future reduction, Appellants third party recovery saved Respondent from paying out a larger compensation under the workers compensation statutes had Appellant 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 Appellant will never take a double recovery.

Lastly, Respondent's citations to non-authoritative case law from other states throughout this matter 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.

C. Appellant has met the elements of reopening his claim pursuant to NRS 613C390, which statutorily requires reopening.

Appellant has further argued in response to Respondent's reasoning of denying reopening his workers compensation claim that he has the medical evidence required to reopen his claim. However, Respondent has attempted to use the "exhaustion" argument (supra) to preclude the Appellant from reopening his workers compensation claim. (APP p. 353 ("he has to expend it on money that would otherwise have been spent on his workers compensation case before he can ask for re-opening"). However, the relevant statute governing reopening a workers compensation claim is NRS 616C.390 which states if a work injury or industrial disease condition changes, the worker may request that the workers' compensation insurer reopen the claim for further medical treatment and benefits.

In this case, the Appellant has presented two letters from two different doctors which together (and one individually) meet the reopening requirements of NRS 616C.390. (APP p. 225 and 227). Both of the doctor's letters together clearly meet the elements (the Appellant having provided analysis of each element outlined in his appeals memorandum (APP p. 219-220)) of NRS 616C.390 which states the insurer shall reopen a claim if the elements are met.

What Appellant is arguing is that his statutory right under NRS 616C.390 cannot be defeated by the application of Respondent's "exhaustion" interpretation

from the *EICON* case. *EICON* is not the standard of reopening. It is the workers' compensation statutes that control the awarding or denial of benefits. *Elizondo v. Hood Mach.*, Inc., 312 P.3d 479, 483. A similar preclusion argument by an insurer was discussed in *Elizondo v. Hood Mach., Inc.* (attempting to use res judicata to prevent the statutory right of reopening), however, this Court rejected this argument because the proper analysis is whether there is a change of circumstances. *Id* at 484 citing to *Jerry's Nugget v. Keith*, 111 Nev. 49, 888 P.2d 921,(Nev. 1995).

Admittedly, this Court in *EICON* does provide a scenario in which an insurer may withhold payment of medical benefits until an employee has exhausted any third-party settlement proceeds. *EICON* at 258. But this is still under the assumption of the facts of the *EICON* case where the claimant still tacitly had remaining settlement funds. *See generally, id* at 257. In this case, Appellant has no third-party settlement funds remaining. Moreover, in the scenario provided in *EICON* the insurer is only entitled to withhold payment of medical benefits not deny claim reopening. *See generally id.*

Simply the standard for reopening a claim is a statutory one generally found in NRS 616C.390, which mandates reopening if its elements are met, as the Appellant has done. And if Respondent believes that the statute must include more requirements to limit an employee's ability to reopen a claim after receiving third-party funds, this effort should be taken up with the Legislature. *See Williams v.*

United Parcel Servs., 129 Nev., 302 P.3d 1144, 1147 (2013) (refusing to deviate from the plain meaning of a statute and rejecting arguments that would require reading additional language into a statute).

1. Appellant does have new medical reporting which meets all the elements of reopening outlined in the statute.

For Appellant to reopen his claim, he must show that there has been a change of circumstances warranting an increase or rearrangement of compensation and that the primary cause of the change in circumstances is the original industrial injury. NRS 616C.390(1) (providing the requirements for claim reopening). Appellant must show, by providing a physician's certificate, that there has been a change of circumstances warranting an increase or rearrangement of compensation, and that the primary cause of the change in circumstances is the original industrial injury. NRS 616C.390(1).

Here, Appellant has through two physicians shown a change of circumstances warranting reopening his workers compensation claim. First, in this case, Respondent was first notified of competent medical evidence showing a change in Mr. Poremba's condition when first presented with Dr. Khanka's Letter. (APP p. 225). Dr. Khanka's Letter asked the Insurer to reopen Mr. Poremba's claim ("we are asking on behalf of Mr. Poremba that you review his case for reopening) based on a showing of increased pain and a worsening condition of Mr. Poremba's work related injuries

found by comparing prior MRI's to new ("But new MRI's show that...the patient's pain has progressed...has worsened since the last MRI"). Dr. Khanka's Letter also identified specific changes to Mr. Poremba's injuries (e.g., "his MRI's then stated...that his Thoracic spine had no bulging or herniation at any level...[b]ut new MRI's show that...patient has disc dehydration and bulging with foraminal stenosis"). It is naturally inferred that when a condition which requires treatment worsens treatment is still needed, i.e., there is a need for treatment. It is also inferred by a request from a claimant's medical provider to reopen his workers compensation claim based on his condition changing and worsening, when comparing new medical evidence to prior, that there is a direct relationship between the work injury and the worsened condition and it is the primary cause for the need to reopen the claim.

However, there should be no mistaken belief that Appellant is relying solely on Dr. Khanka's 2010 report/letter and that there is no new medical reporting to support Appellant's request for reopening. Appellant clearly has additional medical reporting to satisfy the statutory elements of reopening a workers compensation claim. Appellant has pointed and cited and relied on a second doctor's report/letter from Dr. Jeremy Lipshutz from Monos Health Institute. (APP p. 227). And Dr. Lipshutz' doctor's report/letter dated January 21, 2014 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. Appellant's condition has ***changed*** since claim closure ("His pain has worsened over the last two years").
2. Appellant ***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*** Appellant'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. Appellant'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*** Appellant is not to work at his job ("Mr. Poremba is currently unable to work in any capacity").

Simply, despite Respondent's claims otherwise, Appellant does have new medical reporting; and further it meets all the elements of reopening outlined in the statute. And at every stage, Poremba has heavily relied on, explained, applied to the rule, and cited numerous times, his doctor's reports/letters in support of his factual and legal arguments. And for the appeals officer or the District Court—who stated that Poremba "has failed to submit any medical evidence in support of his request" (APP p. 432)—to look past Poremba's heavy reliance on such records without any discussion has prejudiced Appellant.

VI.

CONCLUSION

The Appeals Officer's Order granting the Respondent's summary judgment was procedurally improper when no motion for summary judgment was pending and the decisions by the Appeals Officer fails to meet the requirements of NRS 233B.125 by not offering findings of fact and conclusions of law. More importantly, the standard for reopening a workers compensation claim is NRS 613C.390 and is not case law stretched in its interpretation and improperly applied to the facts. A party's use of inapposite case law cannot be used to defeat statutory requirements, nor can they read additional requirements into a statute. Appellant has met the elements of

reopening his claim pursuant to NRS 613C390, which statutorily requires reopening by presenting new medical reporting showing a worsening in his medical picture related to his work-place accident. Therefore, Appellant should be allowed to reopen his workers compensation claim.

Wherefore, Appellant prays this Court grant Appellant's appeal to the Supreme Court and reverse the Appeals Officer's decision of February 25, 2014 which affirmed the Respondent's denial of reopening Appellant's workers compensation claim.

DATED this 27th day of March, 2015.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this Brief complies with the typeface and type style requirements of Rule 32(a)(4)-(6), by using Microsoft Word to proportionally space 14-point Times New Roman font, and that it complies with the page or type volume limitation under the applicable Rule by not exceeding 30 pages; this brief contains 489 lines and 5,158 words. I also 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 27th day of March, 2015.

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CERTIFICATE OF SERVICE

I certify that on this 27th day of March, 2015, the foregoing APPELLANT'S OPENING BRIEF was submitted by electronic means by e-filing a true copy of the same through this Court's electronic filing system. Electronic notification will be sent to the following:

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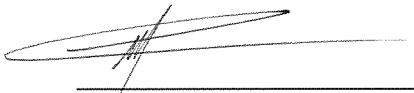

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