INJURED WORKERS

STARTING A CLAIM

A workers' compensation claim is started at a doctor's office when initial treatment is sought. The worker and the doctor together fill out a C-4 form and the medical provider sends the form to the insurance company.

If you think you had an accidental injury during work, at work, because of your work,

or

If you think you have an occupational disease because of the duties of your job:

1) You must inform your employer in writing within 7 days after your accident or after you knew the disease causing disability occurred because of your job; and
2) You must have a doctor file a claim (a C-4 form) with the insurer within 90 days after you knew the injury occurred because of your job or you sought medical treatment or were disabled. The doctor you see for treatment signs and submits the C-4 claim form.

CLAIM DENIAL

If your claim is denied you have 70 days to appeal the denial to the Hearings Division. Complete the appeal form enclosed with the denial letter and send or deliver both the form and a copy of the letter to the address for the Hearings Division which is written on the appeal form. Use the address which is closest to you. (e.g. Northern or Southern Nevada). Make copies of the documents for your records.

If you did not notify your employer of the injury or you did not promptly file a claim, you may have a permitted excuse. Give your employer a written injury report and fill out a C-4 form at a doctor's office as soon as possible.

- Heart disease conditions are not covered unless you are a fireman or policeman.
- Stress-caused conditions are covered only if caused by extreme stress in time of danger.

YOU CAN APPEAL A NEGATIVE DETERMINATION OR A DENIAL OF BENEFITS

You have the right to appeal any written determination regarding your workers' compensation claim. You must file an appeal within 70 days of the date on the insurance company letter or you may lose benefits and experience a delay in medical treatment.

You may also appeal a failure of the insurer to timely respond to your written request for benefits or a determination.

YOU need to file the appeal yourself using the appeal form included with the insurer's letter. Send the form to the Hearings Division.

Enclose a copy of the determination letter from the insurer when you send your appeal to the Hearings Division. Mail the form and a copy of the letter to the address on the form.

Your hearing is limited to the issues in the insurer's letter or the benefits you have asked the insurer to provide in writing. The insurance company is never bound by things they tell you over the phone.

Generally, the strongest evidence to present to a hearing officer is written medical evidence from a doctor. If you prefer, you may appear at a hearing before the hearing officer by phone. Contact the Hearing Office at least a day before the hearing to arrange a telephone appearance. If appearing by phone, mail or fax your evidentiary documents to the hearing office in advance of the hearing.

This hearing is informal. There is no record kept of testimony. You are not required to hire a lawyer. You may represent yourself.

If you receive a decision against you from an a collective bargaining arbitrator, or you are a public safety worker whose special claim was denied, you have the right to appeal directly to the Appeals Office and to request free legal service from NAIW.

PRESENTING YOUR EVIDENCE IN THE INFORMAL HEARING

There are two hearing levels under Nevada's workers' compensation system, the informal level, and the formal level.

Because the first hearing is informal you may represent yourself and you do not need a lawyer.

At the Informal Hearing:

Tell the parts of your story that explain why you appealed and what benefit you want.

Present your evidentiary documents to the hearing officer. You may also present witnesses or written witness statements at the first level hearing.

When you are asked questions, do not guess or assume facts. Only state facts you know.

Do not argue with the hearing officer or the other side. Just present your version of the facts.

Present your evidence and state your case as calmly as you can.

This is your time to try to convince the hearing officer you are entitled to the benefits you seek.

No one knows the facts as well as you do, so describe them. Be short and concise, clear and courteous. You have 10–15 minutes for your case.

If you disagree with the result of the informal hearing the result is not binding if you appeal the decision within **30** days of issuance.

Either side has the right to appeal the decision of a hearing officer if the decision of the hearing officer goes against their interests.

The Office of the Nevada Attorney for Injured Workers is available to answer questions regarding Nevada workers' compensation, or see our website.

APPEALING THE HEARING OFFICER'S DECISION

If you are aggrieved by a hearing officer's decision from the informal hearing (you lost), appeal to the appeals officer for a formal rehearing.

You may also appeal to the appeals officer if you disagree with the decision of the DIR or a collective bargaining arbitrator.

To appeal, you must complete an appeal form
(Request for Hearing Before the Appeals Officer) and file it within **30** days from the date of the decision you are appealing. The appeal form is included along with the initial decision from the hearing officer. Include a copy of the decision when you send in the form.

Any injured worker has the right to ask the appeals officer for the free service of an NAIW attorney for hearings before the appeals officer.

NAIW may be appointed by an appeals officer to represent you. Until an appeals officer appoints NAIW, an NAIW attorney does not represent you.

The request for NAIW attorney representation is made to the Appeals Office.

You may request procedural guidance from NAIW at:

NEVADA ATTORNEY FOR INJURED WORKERS
1000 E. William Street, Suite 208
Carson City, Nevada 89701-3110
Telephone (775) 684-7555
Fax (775) 684-7575

2200 S. Rancho Drive, Suite 230
Las Vegas, Nevada 89102-4413
Telephone (702) 486-2830
Fax (702) 486-2844

WORKERS' COMPENSATION BENEFITS

Temporary Total Disability

Are you entitled to compensation for time lost from work? In what amount?

Temporary Total Disability (TTD) is a benefit to replace wages during times when a doctor writes that you are too hurt to work.

TTD may also be available if a doctor places you on medical restrictions and your employer will not provide you with light duty work that will respect those medical restrictions.

To be eligible for TTD your authorized treating doctor must write that you could not work for at least 5 days in a row after your injury or for 5 days within a 20-day period.

Your average monthly wage is calculated to determine your TTD benefit amount.

Compensation is based upon how much you earned in the 12 weeks before your injury, or 12 months before your injury if that pay average is a better representation of your earnings. You must ask for the 12-month calculation method in writing if you want it to be used.

If you worked more than one job at the time of injury, ask that income from all jobs be added together to calculate your average monthly wage.

Compensation is paid at 66 and 2/3 percent of your average monthly wage (unless you earned more than the published state maximum.)

If you declare tips on your income tax, your tips should be included in your average monthly wage calculation.

If your average monthly wage is incorrect, appeal it. You may ask for a recalculation.

TTD is not available for any time periods during which a worker is incarcerated.

If you must travel more than 50 miles to get to treatment after you return to work, ask for mileage reimbursement in writing.

If your job injury or disease aggravated some other condition you have, and the main reason you need treatment is your job injury, your condition may be covered so file a claim in that event.

Permanent Partial Disability

Are you entitled to an impairment award upon claim closure? In what amount?

If you have a permanent impairment that was caused by your work injury and remains after treatment ends, you may qualify for a monetary award. The insurer must either provide you with a date for a Permanent Partial Disability (PPD) evaluation or explain why it finds you have no possibility of permanent impairment.

PPD is rated according to the AMA *Guides to the Evaluation of Permanent Impairment, 5th ed.,* and depends upon diagnosis and severity of injury.

Your disability rating, your average monthly wage, and your age are used to calculate your award; if one is wrong the award may be wrong.

The procedure for rating a permanent injury is the same whether it is a new claim or a claim that has been reopened. Ratings must be done by a doctor or chiropractor on the Nevada rating panel randomized list set by the Division of Industrial Relations (DIR).

The rating will take into account strength, range of motion, and nerve sensitivity. For spinal injuries, the effect on activities of daily living may also be considered. Generally, pain is not rated but you may ask for ongoing pain management after claim closure. Ask the insurer for this benefit in writing before the claim closes.

A PPD rating may also include certain physiological impairments if they are accepted in the claim.

Make sure all the body parts that were hurt in the original injury are included in the PPD evaluation.

If you disagree with the PPD evaluation you may be entitled to a comparison rating. DIR will give you the name of a rating doctor from the randomized list. Communicate with the insurance company in writing whenever possible. Phone calls do not create appeal rights, but written letters can.

• If you wish to appeal the percentage of physical impairment, or which body parts or conditions are covered, or <u>any other</u> pending issue on your claim, <u>DO NOT TAKE</u> a lump sum settlement, because that ends most issues.

Vocational Rehabilitation

Are you entitled to job retraining services and a living stipend while you are trained?
You may be entitled to retraining benefits if :
• a doctor writes that you have physical restrictions that prevent you from returning to your pre-injury job or the job you were retrained to do;
• your employer at the time you were injured has not offered you a job within your restrictions;
• you are unable to return to work at 80 percent of your wage at the time of your injury.
• you cannot find a job on your own in your area within your physical restrictions. (Your marketable skills will be considered.)
The length and type of program you may qualify for depends upon the percentage of your permanent impairment (see p.4) and your abilities and interests.
You may be eligible for a second program if your first program did not retrain you to a job you can perform within your restrictions.
Services may be available to eligible workers who live outside Nevada within 50 miles of the border, or who live in-state but need benefits out-of-state within 50 miles of the border. You may get services in a state bordering Nevada if you show that such services are more cost-effective than in-state.

Vocational Rehabilitation Buyout

If you take a buyout you will lose your right to all future retraining services no matter how much worse you become or how many times your claim is reopened.

You cannot appeal failure to offer a buyout or the amount of the sum offered, but you may negotiate with the insurer for a better buyout offer.

If you live more than 50 miles outside the Nevada border, generally a buyout is the only rehabilitation benefit provided.

The minimum lump sum amount you are entitled to varies with your rated percentage of permanent impairment.

Contact NAIW for information if you are offered a buyout before you agree to one.

Reopening

Are you entitled to future benefits after your claim is closed?

If the permanent injury from a prior claim gets worse or changes you may request reopening for additional treatment.

A reopening request must include two things:

1. A doctor's written statement that your work injury has gotten worse or changed,
2. A written request from you asking that your claim be reopened.

The key to reopening is a properly worded doctor's letter.

Your doctor must write:

1. Your condition has changed or worsened since claim closure.
2. You need treatment.
3. A description of the treatment needed.
4. That there is a direct relationship between your original work injury and your condition at the time you ask for reopening.
5. Your past work injury is the primary cause of your need to reopen your claim currently.

If, before you filed for reopening, you retired and are getting a pension or voluntarily left the workforce for reasons unrelated to your injury, you are entitled to medical benefits but not wage replacement benefits.

From the date your claim is closed or your reopening request is denied, you cannot make another request to reopen for a year, absent unusual circumstances.

If you originally had no lost time and no Permanent Partial Disability, you must request reopening **within** 1 year of claim closure.

If your claim was closed because your medical treatment cost less than $800 in the first 12 months, you probably cannot reopen.

You may be able to reopen solely to get a Permanent Partial Disability evaluation if you were entitled to it and your case was closed without this benefit.