
ASSEMBLY BILL NO. 470—ASSEMBLYMEN GOLDWATER AND BUCKLEY

MARCH 10, 1999

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes concerning organizations for managed care that provide medical and health care services to injured employees who are entitled to workers' compensation. (BDR 53-1298)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: Yes.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~omitted material~~ is material to be omitted.

AN ACT relating to workers' compensation; requiring organizations for managed care that provide medical and health care services to injured employees to create certain written policies and programs to ensure the effectiveness of the managed care provided by the organization; requiring such organizations for managed care to file a report with the commissioner of insurance concerning its provision of medical and health care services; requiring such organizations for managed care to follow certain procedures before denying medical or health care services to an injured employee; requiring such organizations for managed care to provide coverage for medically necessary emergency services without requiring an injured employee to obtain prior authorization for such services; requiring such organizations for managed care to establish a system for resolving complaints of injured employees; prohibiting such organizations for managed care from engaging in certain practices that restrict the actions of a provider of health care; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE
AND ASSEMBLY, DO ENACT AS FOLLOWS:

- 1 **Section 1.** Chapter 616B of NRS is hereby amended by adding
- 2 thereto the provisions set forth as sections 2 to 18, inclusive, of this act.
- 3 **Sec. 2.** *Any document required to be filed with the commissioner*
- 4 *pursuant to the provisions of sections 2 to 18, inclusive, of this act, other*
- 5 *than medical records and other information relating to a specific injured*
- 6 *employee, must be treated as a public record.*
- 7 **Sec. 3.** *Each organization for managed care shall employ or*
- 8 *contract with a physician who is licensed to practice medicine in the State*

1 of Nevada pursuant to chapter 630 of NRS to serve as its medical
2 director.

3 **Sec. 4.** Each organization for managed care shall:

4 1. Develop and maintain written policies and procedures setting forth
5 the manner in which it conducts utilization review; and

6 2. Require any person with whom it subcontracts to provide
7 utilization review to use the same policies and procedures developed
8 pursuant to subsection 1.

9 **Sec. 5.** 1. In addition to any other report that is required to be filed
10 with the commissioner or the state board of health, each organization for
11 managed care shall file with the commissioner and the state board of
12 health, on or before March 1 of each year, a report regarding its methods
13 for reviewing the quality of medical and health care services provided to
14 injured employees.

15 2. Each organization for managed care shall include in its report the
16 criteria, data, benchmarks or studies used to:

17 (a) Assess the nature, scope, quality and accessibility of medical and
18 health care services provided to injured employees; or

19 (b) Determine any reduction or modification of the provision of
20 medical and health care services to injured employees.

21 3. Except as already required to be filed with the commissioner or
22 the state board of health, if the organization for managed care is not
23 owned and operated by a public entity and provides medical and health
24 care services for more than 100 injured employees, the report filed
25 pursuant to subsection 1 must include:

26 (a) A copy of all of its quarterly and annual financial reports;

27 (b) A statement of any financial interest it has in any other business
28 which is related to medical or health care that is greater than 5 percent of
29 that business or \$5,000, whichever is less; and

30 (c) A description of each complaint filed with or against it that
31 resulted in arbitration, a lawsuit or other legal proceeding, unless
32 disclosure is prohibited by law or a court order.

33 4. A report filed pursuant to this section must be made available for
34 public inspection within a reasonable time after it is received by the
35 commissioner.

36 **Sec. 6.** Any person who receives, collects, disburses or invests money
37 for an organization for managed care is responsible for such money in a
38 fiduciary relationship to the injured employee who is entitled to medical
39 and health care services and to the employer whose insurer has
40 contracted with the organization for managed care.

41 **Sec. 7.** Each organization for managed care shall authorize
42 coverage of a medical or health care service that has been recommended
43 for the injured employee by a provider of health care acting within the

scope of his practice if that service is required to treat the injured employee and not prohibited by the provisions of chapters 616A to 616D, inclusive, and 617 of NRS, unless:

1. The determination not to authorize coverage is made by a physician who:

(a) Is licensed to practice medicine in the State of Nevada pursuant to chapter 630 of NRS;

(b) Possesses the education, training and expertise to evaluate the medical condition of the injured employee; and

(c) Has reviewed the available medical documentation, notes of the attending physician, test results and other relevant medical records of the injured employee.

The physician may consult with other providers of health care in determining whether to authorize coverage.

2. The determination not to authorize coverage and the reason for the decision have been transmitted in writing in a timely manner to the injured employee, the provider of health care who recommended the service and the treating physician or chiropractor of the injured employee, if the treating physician or chiropractor is a different person than the provider of health care who recommended the service.

Sec. 8. 1. Each organization for managed care shall establish written criteria:

(a) Setting forth the manner in which it determines whether to authorize coverage of a medical and health care service; and

(b) Setting forth its method for reviewing standards for the quality of medical and health care services provided to an injured employee.

2. The written criteria must be:

(a) Consistent with the standards of care for the provision of accident benefits established by regulations adopted by the administrator pursuant to NRS 616C.250;

(b) Developed with the assistance of practicing providers of health care;

(c) Developed using generally recognized and, if appropriate, specialized clinical principles and processes;

(d) Reviewed at least one time each year and, if appropriate, updated; and

(e) Made available to an injured employee for review upon request of the injured employee any time that the organization for managed care denies coverage of a specific medical or health care service to the injured employee.

Sec. 9. 1. Each organization for managed care shall provide coverage for medically necessary emergency services.

1 2. An organization for managed care shall not require prior
2 authorization for medically necessary emergency services.

3 3. A plan for managed care:

4 (a) Established by an organization for managed care that has
5 contracted with an insurer; and

6 (b) Applicable to a policy of industrial insurance that is delivered,
7 issued for delivery or renewed on or after the effective date of this
8 act,

9 has the legal effect of including the coverage required by this section,
10 and any provision of the plan that is in conflict with this section is void.

11 4. As used in this section, "medically necessary emergency services"
12 means medical and health care services that are provided to an injured
13 employee by a provider of health care after the sudden onset of a medical
14 condition that manifests itself by symptoms of such sufficient severity
15 that a prudent person would believe that the absence of immediate
16 medical attention could result in:

17 (a) Serious jeopardy to the health of the injured employee;

18 (b) Serious jeopardy to the health of an unborn child of the injured
19 employee;

20 (c) Serious impairment of a bodily function of the injured employee;
21 or

22 (d) Serious dysfunction of any bodily organ or part of the injured
23 employee.

24 **Sec. 10. 1.** Each organization for managed care shall establish a
25 quality assurance program designed to direct, evaluate and monitor the
26 effectiveness of medical and health care services provided to injured
27 employees. The program must include, without limitation:

28 (a) A method for analyzing the outcomes of medical and health care
29 services;

30 (b) Peer review;

31 (c) A system to collect and maintain information related to the
32 medical and health care services provided to injured employees;

33 (d) Recommendations for remedial action; and

34 (e) Written guidelines that set forth the procedures for remedial action
35 when problems related to quality of care are identified.

36 2. Each organization for managed care shall:

37 (a) Maintain a written description of the quality assurance program
38 established pursuant to subsection 1, including, without limitation, the
39 specific actions used by the organization for managed care to promote
40 adequate quality of medical and health care services provided to injured
41 employees and the persons responsible for such actions;

42 (b) Provide information to each provider of health care whom it
43 employs or with whom it contracts to provide medical and health care

1 services to injured employees regarding the manner in which the quality
2 assurance program functions;

3 (c) Provide the necessary staff to implement the quality assurance
4 program and to evaluate the effectiveness of the program; and

5 (d) At least one time each year, review the continuity and effectiveness
6 of the quality assurance program, review any findings of the quality
7 improvement committee established pursuant to section 11 of this act and
8 take any reasonable actions to improve the program.

9 3. Each organization for managed care is responsible for an activity
10 conducted pursuant to its quality assurance program, regardless of
11 whether the organization for managed care or another entity performs
12 the activity.

13 **Sec. 11. 1.** As part of a quality assurance program established
14 pursuant to section 10 of this act, each organization for managed care
15 shall create a quality improvement committee directed by a physician
16 who is licensed to practice medicine in the State of Nevada pursuant to
17 chapter 630 of NRS.

18 2. Each organization for managed care shall:

19 (a) Establish written guidelines setting forth the procedure for
20 selecting the members of the committee;

21 (b) Select members pursuant to such guidelines; and

22 (c) Provide staff to assist the committee.

23 3. The committee shall:

24 (a) Select and review appropriate medical records of injured
25 employees and other data related to the quality of medical and health
26 care provided to injured employees by providers of health care;

27 (b) Review the clinical processes used by providers of health care in
28 providing services;

29 (c) Identify any problems related to the quality of health care provided
30 to injured employees; and

31 (d) Advise providers of health care regarding issues related to quality
32 of care.

33 **Sec. 12. 1.** Each organization for managed care shall establish a
34 system for resolving complaints of an injured employee concerning:

35 (a) Payment or reimbursement for medical and health care services;

36 (b) Availability, delivery or quality of medical and health care
37 services, including, without limitation, an adverse determination made
38 pursuant to utilization review; or

39 (c) The terms and conditions of a plan for managed care.

40 The system must be approved by the commissioner in consultation with
41 the state board of health.

42 2. If an injured employee makes an oral complaint, an organization
43 for managed care shall inform the injured employee that if he is not

1 *satisfied with the resolution of the complaint, he must file the complaint*
2 *in writing to receive further review of the complaint.*

3 *3. Each organization for managed care shall:*

4 *(a) Upon request, assign an employee of the organization for*
5 *managed care to assist an injured employee or other person in filing a*
6 *complaint or appealing a determination of the review board;*

7 *(b) Authorize an injured employee who appeals a determination of the*
8 *review board to appear before the review board to present testimony at a*
9 *hearing concerning the appeal; and*

10 *(c) Authorize an injured employee to introduce any documentation*
11 *into evidence at a hearing of a review board and require an injured*
12 *employee to provide the documentation required by the plan for managed*
13 *care or by the insurer to the review board not later than 5 business days*
14 *before a hearing of the review board.*

15 *4. The commissioner or the state board of health may examine the*
16 *system for resolving complaints established pursuant to this section at*
17 *such times as either deems necessary or appropriate.*

18 **Sec. 13. 1. A system for resolving complaints created pursuant to**
19 **section 12 of this act must include, without limitation:**

20 *(a) An initial investigation;*

21 *(b) A review of the complaint by a review board;*

22 *(c) A procedure for appealing a determination regarding the*
23 *complaint; and*

24 *(d) A clear description of what constitutes a final determination*
25 *pursuant to the system for resolving complaints.*

26 *2. The majority of the members of the review board must be injured*
27 *employees who receive medical and health care services from the*
28 *organization for managed care.*

29 *3. Except as otherwise provided in subsection 4, a review board shall*
30 *complete its review regarding a complaint or appeal and notify the*
31 *injured employee of its determination not later than 14 days after the*
32 *complaint or appeal is filed, unless the injured employee and the review*
33 *board have agreed to a longer period of time.*

34 *4. If a complaint involves an imminent and serious threat to the*
35 *health of the injured employee, the organization for managed care shall*
36 *inform the injured employee immediately of his right to an expedited*
37 *review of his complaint. If an expedited review is required, the review*
38 *board shall notify the injured employee in writing of its determination*
39 *within 72 hours after the complaint is filed. Notwithstanding the*
40 *provisions of NRS 616C.370, a determination of the review board made*
41 *pursuant to this subsection constitutes a final determination for purposes*
42 *of* **judicial** *review.*

1 5. Notice provided to an injured employee by a review board
2 regarding a complaint must include, without limitation, an explanation
3 of any further rights of the injured employee regarding the complaint
4 that are available under the plan for managed care established by the
5 organization for managed care.

6 **Sec. 14.** 1. Each organization for managed care shall submit to the
7 commissioner and the state board of health an annual report regarding
8 its system for resolving complaints established pursuant to section 12 of
9 this act on a form prescribed by the commissioner in consultation with
10 the state board of health that includes, without limitation:

11 (a) A description of the procedures used for resolving complaints of
12 an injured employee;

13 (b) The total number of complaints and appeals handled through the
14 system for resolving complaints since the last report and a compilation of
15 the causes underlying the complaints filed;

16 (c) The current status of each complaint and appeal filed; and

17 (d) The average amount of time that was needed to resolve a
18 complaint and an appeal, if any.

19 2. Each organization for managed care shall maintain records of
20 complaints filed with it that concern something other than medical or
21 health care services and shall submit to the commissioner a report
22 summarizing those complaints at such times and in such format as the
23 commissioner may require.

24 **Sec. 15.** 1. Following approval by the commissioner, each
25 organization for managed care shall provide written notice to an injured
26 employee, in clear and comprehensible language that is understandable
27 to an ordinary layperson, explaining the right of the injured employee to
28 file a written complaint and to obtain an expedited review pursuant to
29 section 13 of this act. The notice must be provided to an injured
30 employee:

31 (a) At the time he is hired by the employer whose insurer has
32 contracted with the organization for managed care;

33 (b) Any time that the organization for managed care denies coverage
34 of a medical or health care service or limits coverage of a medical or
35 health care service to an injured employee; and

36 (c) Any other time deemed necessary by the commissioner.

37 2. Any time that an organization for managed care denies coverage
38 of a medical or health care service to an injured employee it shall notify
39 the injured employee in writing of:

40 (a) The reason for denying coverage of the service;

41 (b) The criteria by which the organization for managed care or
42 insurer determines whether to authorize or deny coverage of the medical
43 or health care service; and

1 (c) *His right to file a written complaint.*

2 3. *A written notice which is approved by the commissioner shall be*
3 *deemed to be in clear and comprehensible language that is*
4 *understandable to an ordinary layperson.*

5 **Sec. 16.** *An organization for managed care shall not restrict or*
6 *interfere with any communication between a provider of health care and*
7 *an injured employee regarding any information that the provider of*
8 *health care determines is relevant to the health care of the injured*
9 *employee.*

10 **Sec. 17.** *An organization for managed care shall not terminate a*
11 *contract with, demote, refuse to contract with or refuse to compensate a*
12 *provider of health care solely because the provider, in good faith:*

13 1. *Advocates in private or in public on behalf of an injured*
14 *employee;*

15 2. *Assists an injured employee in seeking reconsideration of a*
16 *determination by the organization for managed care to deny coverage for*
17 *a medical or health care service; or*

18 3. *Reports a violation of law to an appropriate authority.*

19 **Sec. 18.** 1. *An organization for managed care shall not offer or*
20 *pay any type of material inducement, bonus or other financial incentive*
21 *to a provider of health care to deny, reduce, withhold, limit or delay*
22 *specific medically necessary medical or health care services to an injured*
23 *employee.*

24 2. *The provisions of this section do not prohibit an arrangement for*
25 *payment between an organization for managed care and a provider of*
26 *health care that uses capitation or other financial incentives, if the*
27 *arrangement is designed to provide an incentive to the provider of health*
28 *care to use medical and health care services effectively and consistently*
29 *in the best interest of the treatment of the injured employee.*

30 **Sec. 19.** NRS 616B.515 is hereby amended to read as follows:

31 616B.515 1. Except as otherwise provided in NRS 616B.518, the
32 manager may enter into a contract or contracts with one or more
33 organizations for managed care, including health maintenance
34 organizations, to provide comprehensive medical and health care services
35 to injured employees whose employers are insured by the system for
36 injuries and diseases that are compensable under chapters 616A to 617,
37 inclusive, of NRS. The contract or contracts must be awarded pursuant to
38 reasonable competitive bidding procedures as established by the manager.

39 2. After the selection of an organization for managed care, the bids
40 received by the manager and the records related to the bidding are subject
41 to review by any member of the public upon request.

42 3. An organization for managed care or a health maintenance
43 organization ~~{shall}~~ *chosen pursuant to this section:*

1 **(a) Shall** not discriminate against or exclude a provider of health care
2 from participation in the organization's proposed plan for providing
3 medical and health care services because of race, creed, sex, national
4 origin, age or disability.

5 **(b) Shall comply with the provisions of sections 2 to 18, inclusive, of**
6 **this act.**

7 **Sec. 20.** NRS 616B.527 is hereby amended to read as follows:

8 616B.527 A self-insured employer, an association of self-insured
9 public or private employers or a private carrier may:

10 1. Enter into a contract or contracts with one or more organizations for
11 managed care to provide comprehensive medical and health care services
12 to employees for injuries and diseases that are compensable pursuant to
13 chapters 616A to 617, inclusive, of NRS.

14 2. Enter into a contract or contracts with providers of health care,
15 including, without limitation, physicians who provide primary care,
16 specialists, pharmacies, physical therapists, radiologists, nurses, diagnostic
17 facilities, laboratories, hospitals and facilities that provide treatment to
18 outpatients, to provide medical and health care services to employees for
19 injuries and diseases that are compensable pursuant to chapters 616A to
20 617, inclusive, of NRS.

21 3. Use the services of an organization for managed care that has
22 entered into a contract with the manager pursuant to NRS 616B.515, but is
23 not required to use such services.

24 4. Require employees to obtain medical and health care services for
25 their industrial injuries from those organizations and persons with whom
26 the self-insured employer, association or private carrier has contracted
27 pursuant to subsections 1 and 2, or as the self-insured employer,
28 association or private carrier otherwise prescribes.

29 5. ~~Require~~ **Except as otherwise provided in section 9 of this act,**
30 **require** employees to obtain the approval of the self-insured employer,
31 association or private carrier before obtaining medical and health care
32 services for their industrial injuries from a provider of health care who has
33 not been previously approved by the self-insured employer, association or
34 private carrier.

35 6. **An organization for managed care with whom a self-insured**
36 **employer, association of self-insured public or private employers or a**
37 **private carrier has contracted pursuant to this section shall comply with**
38 **the provisions of sections 2 to 18, inclusive, of this act.**

39 **Sec. 21.** NRS 616C.305 is hereby amended to read as follows:

40 616C.305 1. Except as otherwise provided in subsection ~~3,~~ 2, any
41 person who is aggrieved by a ~~decision~~ **final determination** concerning
42 accident benefits made by an organization for managed care which has
43 contracted with an insurer must, within 14 days of the ~~decision~~

1 **determination** and before requesting a resolution of the dispute pursuant to
2 NRS 616C.345 to 616C.385, inclusive, appeal that ~~{decision}~~
3 **determination** in accordance with the procedure for resolving complaints
4 established by the organization for managed care. *If the aggrieved person*
5 *is an injured employee, he must appeal that decision in accordance with*
6 *the provisions of sections 12 and 13 of this act and the system for*
7 *resolving complaints established by the organization for managed care*
8 *pursuant thereto.*

9 2. ~~{The procedure for resolving complaints established by the~~
10 ~~organization for managed care must be informal and must include, but is~~
11 ~~not limited to, a review of the appeal by a qualified physician or~~
12 ~~chiropractor who did not make or otherwise participate in making the~~
13 ~~decision.~~

14 ~~—3.1~~ If a person appeals a final determination pursuant to a procedure
15 for resolving complaints established by an organization for managed care
16 and the dispute is not resolved within ~~{14}~~ 30 days after it is submitted ~~{}~~
17 *or, if the aggrieved person is an injured employee, the longer period*
18 *agreed to by an injured employee and the review board pursuant to*
19 *section 13 of this act*, he may request a resolution of the dispute pursuant
20 to NRS 616C.345 to 616C.385, inclusive.

21 **Sec. 22.** NRS 616C.345 is hereby amended to read as follows:

22 616C.345 1. Any party aggrieved by a decision of the hearing officer
23 relating to a claim for compensation may appeal from the decision by
24 filing a notice of appeal with an appeals officer within 30 days after the
25 date of the decision.

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

28 (a) A final ~~{decision}~~ **determination** was rendered pursuant to that
29 procedure; or

30 (b) The dispute was not resolved pursuant to that procedure within ~~{14}~~
31 30 days after it was submitted ~~{}~~ *or the longer period agreed to by an*
32 *injured employee and the review board pursuant to section 13 of this*
33 *act,*

34 any party to the dispute may file a notice of appeal within 70 days after the
35 date on which the final ~~{decision}~~ **determination** was mailed to the
36 employee, or his dependent, or the unanswered request for resolution was
37 submitted. Failure to render a written ~~{decision}~~ **determination** within 30
38 days after receipt of such a request, *or the longer period agreed to by an*
39 *injured employee and the review board pursuant to section 13 of this act,*
40 shall be deemed by the appeals officer to be a denial of the request.

41 3. Except as otherwise provided in NRS 616C.380, the filing of a
42 notice of appeal does not automatically stay the enforcement of the
43 decision of a hearing officer or a ~~{decision}~~ **determination** rendered

1 pursuant to NRS 616C.305. The appeals officer may order a stay, when
2 appropriate, upon the application of a party. If such an application is
3 submitted, the decision is automatically stayed until a determination is
4 made concerning the application. A determination on the application must
5 be made within 30 days after the filing of the application. If a stay is not
6 granted by the officer after reviewing the application, the decision must be
7 complied with within 10 days after the date of the refusal to grant a stay.

8 4. Except as otherwise provided in this subsection, the appeals officer
9 shall, within 10 days after receiving a notice of appeal pursuant to this
10 section or a contested claim pursuant to subsection 5 of NRS 616C.315,
11 schedule a hearing on the merits of the appeal or contested claim for a date
12 and time within 90 days after his receipt of the notice and give notice by
13 mail or by personal service to all parties to the matter and their attorneys or
14 agents at least 30 days before the date and time scheduled. A request to
15 schedule the hearing for a date and time which is:

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

18 (b) More than 90 days after the receipt of the notice or claim,
19 may be submitted to the appeals officer only if all parties to the appeal or
20 contested claim agree to the request.

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

23 6. Failure to file a notice of appeal within the period specified in
24 subsection 1 or 2 may be excused if the party aggrieved shows by a
25 preponderance of the evidence that he did not receive the notice of the
26 ~~decision~~ **determination** and the forms necessary to appeal the ~~decision~~
27 **determination**. The claimant, employer or insurer shall notify the hearing
28 officer of a change of address.

29 **Sec. 23.** The provisions of this act apply to all contracts between an
30 insurer and an organization for managed care for the provisions of
31 comprehensive medical and health care services to injured employees
32 entered into or renewed on or after October 1, 1999.