

SENATE BILL NO. 354—SENATOR CARE

MARCH 10, 1999

Referred to Committee on Commerce and Labor

SUMMARY—Requires insurer, third-party administrator or organization for managed care to provide upon request review by physician of decision to withhold or deny prior authorization for certain services ordered by treating physician or chiropractor. (BDR 53-1261)

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 an insurer, third-party administrator or organization for managed care to provide upon request a review by a physician of a decision to withhold or deny prior authorization for certain services ordered by the treating physician or chiropractor of an injured employee; requiring the insurer, third-party administrator or organization for managed care to authorize such services if the physician determines the services are necessary; 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 616C of NRS is hereby amended by adding thereto
2 a new section to read as follows:
3 ***1. If an insurer, third-party administrator or an organization for***
4 ***managed care:***
5 ***(a) Within 5 working days after receiving a request, does not give its***
6 ***prior authorization or denies prior authorization for services that:***
7 ***(1) Require prior authorization pursuant to law or the rules of the***
8 ***organization for managed care; and***
9 ***(2) Have been ordered by the treating physician or chiropractor of***
10 ***an injured employee; and***
11 ***(b) Does not demonstrate that a physician participated in the***
12 ***determination to withhold or deny prior authorization,***
13 ***the provider of health care who would provide the ordered services or the***
14 ***injured employee may request that a physician employed by or under***

1 *contract with the insurer, third-party administrator or organization for*
2 *managed care review the request for prior authorization. Demonstration*
3 *that a physician participated in the determination to withhold or deny*
4 *prior authorization must be made by providing a written evaluation of the*
5 *request for prior authorization that is signed by the physician as an*
6 *attestation that he approves or endorses the contents contained therein.*

7 *2. Within 5 working days after an insurer, third-party administrator*
8 *or organization for managed care receives a request for review by a*
9 *physician pursuant to subsection 1, a physician employed by or under*
10 *contract with the insurer, third-party administrator or organization for*
11 *managed care shall review the request for prior authorization and*
12 *determine whether the services ordered by the treating physician or*
13 *chiropractor are necessary to the recovery of the injured employee. If the*
14 *physician determines that the services ordered are necessary to the*
15 *recovery of the injured employee, the insurer, third-party administrator*
16 *or organization for managed care shall ensure that prior authorization is*
17 *given directly to the provider of health care who will provide the ordered*
18 *services to the employee within 1 day after the physician makes his*
19 *determination.*

20 **Sec. 2.** NRS 616C.305 is hereby amended to read as follows:

21 616C.305 1. Except as otherwise provided in subsection 3, any
22 person who is aggrieved by a decision concerning accident benefits made
23 by an organization for managed care which has contracted with an insurer
24 must, within 14 days of the decision and before requesting a resolution of
25 the dispute pursuant to NRS 616C.345 to 616C.385, inclusive, appeal that
26 decision in accordance with the procedure for resolving complaints
27 established by the organization for managed care.

28 2. The procedure for resolving complaints established by the
29 organization for managed care must be informal and must include, but is
30 not limited to, a review of the appeal by a qualified physician or
31 chiropractor who did not make or otherwise participate in making the
32 decision.

33 3. If a person appeals a final determination pursuant to a procedure for
34 resolving complaints established by an organization for managed care and
35 the dispute is not resolved within 14 days after it is submitted, he may
36 request a resolution of the dispute pursuant to NRS 616C.345 to 616C.385,
37 inclusive.

38 *4. As used in this section and as applied to a person who has,*
39 *pursuant to the provisions of section 1 of this act, requested an*
40 *organization for managed care to provide a review by a physician of a*
41 *request for prior authorization for certain services, the term “decision*
42 *concerning* **accident** **benefits”:**

- 1 *(a) Refers to the determination made by that physician after reviewing*
- 2 *the request for prior authorization.*
- 3 *(b) Does not refer to the initial denial of prior authorization or failure*
- 4 *to provide prior authorization by the organization for managed care.*

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