REQUIRES TWO-THIRDS MAJORITY VOTE (§ 1)

A.B. 422

ASSEMBLY BILL NO. 422–ASSEMBLYMEN BUCKLEY, FREEMAN, PARKS, MANENDO, NEIGHBORS, ANDERSON, ARBERRY, BACHE, CHOWNING, CLABORN, COLLINS, GIBBONS, GIUNCHIGLIANI, LEE, LESLIE, MCCLAIN, MORTENSON, PARNELL, PRICE AND SMITH

MARCH 19, 2001

Referred to Committee on Commerce and Labor

SUMMARY—Provides for external review of certain determinations made by managed care organizations and health maintenance organizations. (BDR 57-1092)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: 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 health care; requiring an external review organization to be certified by the commissioner of insurance before conducting an external review of a final adverse determination of a managed care organization or health maintenance organization; authorizing an insured under certain health care plans to submit to a managed care organization or health maintenance organization a request for such a review under certain circumstances; requiring an external review organization to approve, modify or reverse a final adverse determination within a certain period; providing that an external review organization is not liable in a civil action for damages relating to a determination issued by the external review organization under certain circumstances; requiring the director of the office for consumer health assistance to contract with certain external review organizations; and providing other matters properly relating thereto.

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

Section 1. Chapter 683A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An external review organization shall not conduct an external review of a final adverse determination pursuant to sections 4 to 12, inclusive, of this act unless it is certified in accordance with regulations adopted by the commissioner. The regulations must include, without limitation, provisions setting forth:

(a) The manner in which an external review organization may apply for a certificate and the requirements for the issuance and renewal of the certificate pursuant to this section;

(b) The grounds for which the commissioner may refuse to issue, suspend, revoke or refuse to renew a certificate issued pursuant to this section; and

(c) The manner and circumstances under which an external review organization is required to conduct its business.

2. The regulations must include provisions for issuing a certificate specified in subsection 1 to an external review organization that submits evidence satisfactory to the commissioner that the external review organization is certified to conduct external reviews of final adverse determinations by the National Committee for Quality Assurance, the American Accreditation Health Care Commission or any other nationally recognized organization approved by the commissioner.

3. A certificate issued pursuant to this section expires 1 year after it is issued and may be renewed in accordance with regulations adopted by the commissioner.

4. The commissioner shall ensure that each external review organization which is certified pursuant to this section:

(a) Uses only clinical peers to conduct external reviews;

(b) Is not a subsidiary of, or owned or controlled by, a health plan, a trade association of health plans or a professional association of health care providers; and

(c) Complies with the provisions of this section and sections 4 to 12, inclusive, of this act and any regulations adopted by the commissioner pursuant to those sections.

5. The commissioner shall ensure that an external review organization that is certified pursuant to this section or any clinical peer who conducts or participates in an external review for the external review organization, or any member of his immediate family, does not have a financial interest in:

(a) A managed care organization that submits a final adverse determination to the external review organization pursuant to sections 4 to 12, inclusive, of this act or any officer, director or manager of the managed care organization; or

(b) The medical group of a physician or any organization that provides health care services to an insured under a health care plan for which a final adverse determination is made.

6. The commissioner may charge and collect a fee for issuing or renewing a certificate of an external review organization pursuant to this section. The fee must not exceed the cost of issuing or renewing the certificate.

7. The commissioner shall annually prepare and make available to the general public a list that includes the name of each external review organization which is issued a certificate or whose certificate is renewed pursuant to this section during the year immediately preceding the year in which the commissioner prepares the list.

8. As used in this section:

(a) "Clinical peer" has the meaning ascribed to it in section 5 of this act.

(b) "External review organization" has the meaning ascribed to it in section 6 of this act.

(c) "Final adverse determination" has the meaning ascribed to it in section 7 of this act.

Sec. 2. NRS 695C.260 is hereby amended to read as follows:

695C.260 ~~[Every]~~ ***Each*** health maintenance organization shall establish ~~[a]~~ ***:***

1. A complaint system which complies with the provisions of NRS 695G.200 to 695G.230, inclusive ~~[.]~~ ***; and***

2. A system for conducting external reviews of final adverse determinations that complies with the provisions of sections 4 to 12, inclusive, of this act.

Sec. 3. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 4 to 12, inclusive, of this act.

Sec. 4. ***"Authorized representative" means a person who has obtained the consent of an insured to represent him in an external review of a final adverse determination conducted pursuant to sections 4 to 12, inclusive, of this act.***

Sec. 5. ***"Clinical peer" means a physician who is:***

1. Engaged in the practice of medicine;

2. Licensed pursuant to the provisions of chapter 630 or 633 of NRS; and

3. Certified or is eligible for certification by the board of medical examiners in the same or similar area of practice as is the health care service that is the subject of a final adverse determination.

Sec. 6. ***"External review organization" means an organization that:***

1. Conducts an external review of a final adverse determination;

2. Is certified by the commissioner in accordance with section 1 of this act; and

3. Has contracted with the director of the office for consumer health assistance to conduct external reviews of final adverse determinations pursuant to subsection 8 of NRS 223.560.

Sec. 7. ***"Final adverse determination" means a final decision of a managed care organization to deny, reduce or terminate coverage for health care services or to deny payment for those services concerning a complaint filed pursuant to NRS 695G.200 because the health care services were determined to be:***

1. Medically unnecessary;

2. Not covered under the health care plan of the insured;

3. Experimental or investigational; or

4. Provided by a provider of health care who was chosen by the insured in violation of the terms and conditions of his health care plan.

The term does not include a determination relating to a claim for workers' compensation pursuant to chapters 616A to 617, inclusive, of NRS.

Sec. 8. ***"Life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or medical condition is interrupted.***

Sec. 9. *1. If an insured or a physician of an insured receives notice of a final adverse determination from a managed care organization concerning the insured, and if the insured is required to pay $500 or more for the health care services that are the subject of the final adverse determination, the insured, the physician of the insured or an authorized representative may, within 90 days after receiving notice of the final adverse determination, submit a request to the managed care organization for an external review of the final adverse determination.*

2. Within 3 days after receiving a request pursuant to subsection 1, the managed care organization shall:

(a) Notify the insured, his authorized representative or his physician, the agent who performed utilization review for the managed care organization, if any, and the office for consumer health assistance that the request has been filed with the managed care organization; and

(b) Provide to an external review organization all documents and materials relating to the final adverse determination, including, without limitation:

(1) Any medical records of the insured relating to the external review;

(2) A copy of the provisions of the health care plan upon which the final adverse determination was based;

(3) Any documents used by the managed care organization to make the final adverse determination;

(4) The reasons for the final adverse determination; and

(5) Insofar as practicable, a list that specifies each provider of health care who has provided health care to the insured and the medical records of the provider of health care relating to the external review.

Sec. 10. *1. Upon receipt of a request for an external review pursuant to section 9 of this act, the external review organization shall, within 5 days after receiving the request:*

(a) Review the request and the documents and materials submitted pursuant to section 9 of this act; and

(b) Notify the insured, his physician and the managed care organization if any additional information is required to conduct a review of the final adverse determination.

2. Except as otherwise provided in subsection 3, the external review organization shall approve, modify or reverse the final adverse determination within 15 days after it receives the information required to make that determination pursuant to this section, but in no case later than 20 days after the external review organization receives the request for an external review. The external review organization shall submit a copy of its determination, including the reasons therefor, to:

(a) The insured;

(b) The physician of the insured;

(c) The authorized representative of the insured, if any;

(d) The managed care organization; and

(e) The director of the office for consumer health assistance.

3. If the insured who submitted the request for an external review has a life-threatening condition, the external review organization shall

approve, modify or reverse the final adverse determination as soon as practicable, but not later than 72 hours after it receives the request for review.

4. If the issue concerning the external review is whether the health care services are covered under the terms and conditions of the health care plan of the insured, the external review organization shall notify the commissioner of that fact as soon as practicable after receiving the request for an external review. Upon receipt of the information required to make the determination, the commissioner shall:

(a) Issue a determination concerning that benefit within the periods prescribed in this section; and

(b) Submit the results of his determination to each person specified in subsection 2.

5. In making a determination pursuant to this section, an external review organization or any clinical peer who conducts or participates in an external review of a final adverse determination for the external review organization shall consider, without limitation:

(a) The medical records of the insured;

(b) Any recommendations of the physician of the insured;

(c) Any generally accepted medical guidelines, including guidelines established by the Federal Government or any national or professional society, board or association that establishes such guidelines approved by the commissioner; and

(d) Any applicable criteria relating to adverse final determinations established and used by the managed care organization or the agent it designates to perform utilization review.

Sec. 11. *1. A determination issued by an external review organization pursuant to sections 4 to 12, inclusive, of this act is binding upon the managed care organization and the insured except to the extent that the insured has other remedies pursuant to any federal or state law.*

2. An external review organization or any clinical peer who conducts or participates in an external review of a final adverse determination for the external review organization is not liable in a civil action for damages relating to a determination made by the external review organization if the determination is made in good faith and without gross negligence.

3. The cost of conducting an external review of a final adverse determination pursuant to sections 4 to 12, inclusive, of this act must be paid to the office for consumer assistance by the managed care organization that made the final adverse determination.

Sec. 12. *In lieu of resolving a complaint of an insured in accordance with a system for resolving complaints established pursuant to the provisions of NRS 695G.200, a managed care organization may:*

1. Submit the complaint to an external review organization pursuant to the provisions of sections 4 to 12, inclusive, of this act; or

2. If a federal law or regulation provides a procedure for submitting the complaint for resolution that the commissioner determines is substantially similar to the procedure for submitting the complaint to an external review organization pursuant to sections 4 to 12, inclusive, of

this act, submit the complaint for resolution in accordance with the federal law or regulation.

Sec. 13. NRS 695G.010 is hereby amended to read as follows:

695G.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 695G.020 to 695G.080, inclusive, ***and sections 4 to 8, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 14. NRS 695G.210 is hereby amended to read as follows:

695G.210 1. ~~[A]~~ ***Except as otherwise provided in section 12 of this act, a*** system for resolving complaints created pursuant to NRS 695G.200 must include, without limitation, an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members of the review board must be insureds who receive health care services from the managed care organization.

2. Except as otherwise provided in subsection 3, a review board shall complete its review regarding a complaint or appeal and notify the insured of its determination not later than 30 days after the complaint or appeal is filed, unless the insured and the review board have agreed to a longer period . ~~[of time.]~~

3. If a complaint involves an imminent and serious threat to the health of the insured, the managed care organization shall inform the insured immediately of his right to an expedited review of his complaint. If an expedited review is required, the review board shall notify the insured in writing of its determination within 72 hours after the complaint is filed.

4. Notice provided to an insured by a review board regarding a complaint must include, without limitation, an explanation of any further rights of the insured regarding the complaint that are available under his health care plan.

Sec. 15. NRS 695G.230 is hereby amended to read as follows:

695G.230 1. ~~[Following]~~ ***After*** approval by the commissioner, each managed care organization shall provide ***a*** written notice to an insured, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the insured to file a written complaint and to obtain an expedited review pursuant to NRS 695G.210. Such ***a*** notice must be provided to an insured:

(a) At the time he receives his certificate of coverage or evidence of coverage;

(b) Any time that the managed care organization denies coverage of a health care service or limits coverage of a health care service to an insured; and

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

2. ~~[Any time that]~~ ***If*** a managed care organization denies coverage of a health care service to an insured, including, without limitation, a health maintenance organization that denies a claim related to a health care plan pursuant to NRS 695C.185, it shall notify the insured in writing within 10 working days after it denies coverage of the health care service of:

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

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

(c) His right to ~~[file]~~ ***:***

(1) File a written complaint and the procedure for filing such a complaint ~~[.]~~ ***;***

(2) Appeal a final adverse determination pursuant to sections 4 to 12, inclusive, of this act;

(3) Receive an expedited external review of a final adverse determination if he has a life-threatening condition, including notification of the procedure for requesting the expedited external review;

(4) Receive assistance from any person, including an attorney, for an external review of a final adverse determination; and

(5) Appear before any external review organization to which he has appealed a final adverse determination and submit any evidence to that external review organization relating to the final adverse determination.

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

Sec. 16. NRS 223.560 is hereby amended to read as follows:

223.560 The director shall:

1. Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

2. Assist consumers and injured employees in understanding their rights and responsibilities under health care plans and policies of industrial insurance;

3. Identify and investigate complaints of consumers and injured employees regarding their health care plans and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:

(a) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(b) Providing counseling and assistance to consumers and injured employees concerning health care plans and policies of industrial insurance;

4. Provide information to consumers and injured employees concerning health care plans and policies of industrial insurance in this state;

5. Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the office;

6. Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the director pursuant to this section; ~~[and]~~

7. In appropriate cases and pursuant to the direction of the governor, refer a complaint or the results of an investigation to the attorney general for further action ~~[.]~~ ***; and***

8. On or before January 1 of each year, and in accordance with regulations adopted by the commissioner of insurance, contract with an external review organization that is certified by the commissioner of insurance pursuant to section 1 of this act to conduct external reviews of final adverse determinations in accordance with the provisions of sections 4 to 12, inclusive, of this act. A contract entered into pursuant to this subsection may be renewed by the director.

Sec. 17. NRS 223.580 is hereby amended to read as follows:

223.580 On or before February 1 of each year, the director shall submit a written report to the governor, and to the director of the legislative counsel bureau for transmittal to the appropriate committee or committees of the legislature. The report must include, without limitation:

1. A statement setting forth the number and geographic origin of the written and telephonic inquiries received by the office and the issues to which those inquiries were related;

2. A statement setting forth the type of assistance provided to each consumer and injured employee who sought assistance from the director, including, without limitation, the number of referrals made to the attorney general pursuant to subsection 7 of NRS 223.560; ~~[and]~~

3. A statement setting forth the disposition of each inquiry and complaint received by the director ~~[.]~~ ***; and***

4. A statement setting forth the number of external reviews conducted by external review organizations pursuant to sections 4 to 12, inclusive, of this act and the disposition of each of those reviews.

Sec. 18. This act becomes effective upon passage and approval for the purpose of adopting regulations by the commissioner of insurance to carry out the provisions of this act and on July 1, 2002, for all other purposes.