ASSEMBLY BILL NO. 44–COMMITTEE ON COMMERCE AND LABOR

PREFILED JANUARY 26, 2001

(ON BEHALF OF LEGISLATIVE COMMITTEE ON WORKERS' COMPENSATION (NRS 218.5375))

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes relating to responsibilities of insurers who provide industrial insurance. (BDR 53-772)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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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 industrial insurance; revising the provisions requiring the administrator of the division of industrial relations of the department of business and industry to conduct audits of insurers; revising the provisions governing maintenance of files of claims at the office of an insurer; clarifying the authority of a board of trustees of an association of self-insured public employers to invest certain money; requiring insurers, organizations for managed care and certain employers to notify an injured employee if a medical bill submitted on his behalf is denied and that the injured employee has a right to appeal the denial; 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. NRS 616B.003 is hereby amended to read as follows:

616B.003 1. The administrator shall cause to be conducted at least every **[**~~3~~**]** ***5*** years an audit of all insurers who provide benefits to injured employees pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS. **[**~~The administrator shall cause to be conducted~~**]**

2. In addition to the audit conducted pursuant to subsection 1, the administrator:

(a) Shall, each year on a random basis **[**~~additional~~**]** ***, cause to be conducted*** partial audits of any insurer who has a history of violations of the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, or the regulations adopted pursuant thereto, as determined by the administrator.

~~[2.]~~ ***(b) May, at any time, cause to be conducted an audit that examines a fewer number of files than the audit conducted pursuant to subsection 1 of any insurer who does not have a history of violations of the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, or the regulations adopted pursuant thereto, as determined by the administrator.***

3. The administrator shall require the use of standard auditing procedures and shall establish a manual to describe the standard auditing procedures ~~[.]~~ ***for the audits conducted pursuant to subsections 1 and 2.*** The manual must include:

(a) Specific audit objectives;

(b) Standards for documentation;

(c) Policies for supervisory review;

(d) Policies for the training of auditors;

(e) The format for the audit report; and

(f) Procedures for the presentation, distribution and retention of the audit report ~~[.~~

~~3.]~~ ***,***

for each type of audit conducted pursuant to subsections 1 and 2.

4. In consultation with and with the permission of the commissioner, the audits required or authorized to be conducted pursuant to subsections 1 and 2 may be conducted in conjunction with an audit or examination conducted by the division of insurance of the department of business and industry or the commissioner pursuant to chapters 616A to 617, inclusive, or Title 57 of NRS.

5. The commissioner and the administrator shall establish a procedure for sharing information between the division of insurance of the department of business and industry and the division concerning the qualifications of employers as self-insured employers pursuant to NRS 616B.300 or as an association of self-insured public or private employers pursuant to NRS 616B.353.

~~[4.]~~ ***6.*** On or before March 1 of each year, the administrator shall make a report of each audit to the legislature, if it is in session, or to the interim finance committee if the legislature is not in session.

Sec. 2. NRS 616B.021 is hereby amended to read as follows:

616B.021 1. An insurer shall provide access to the files of claims in its offices.

2. ~~[A file is]~~ ***The physical records in a file concerning a claim filed in this state may be kept at an office located outside this state if all records in the file are accessible at offices located in this state on computer in a microphotographic, electronic or other similar format that produces an accurate reproduction of the original. Except as otherwise provided in this subsection, the records in a file concerning a claim filed in this state must be reproduced and*** available for inspection during regular business hours ***within 24 hours after requested*** by the employee or his designated agent, the employer or his designated agent ~~[and]~~ ***, or*** the administrator or his designated agent. ***If a claim filed in this state has been closed, the records in the file must be reproduced and available for inspection***

during regular business hours within 30 calendar days after requested by such persons.

3. Upon request, the insurer shall make copies ***or other reproductions*** of anything in the file and may charge a reasonable fee for this service. Copies ***or other reproductions*** of materials in the file which are requested by the administrator or his designated agent, or the Nevada attorney for injured workers or his designated agent must be provided free of charge.

~~4. [If a claim has been closed for at least 1 year, the insurer may microphotograph or film any of its records relating to that claim. The microphotographs or films must be placed in convenient and accessible files.~~

~~5.]~~ The administrator ~~[shall]~~ ***may*** adopt regulations concerning the:

(a) Maintenance of records in a file on current or closed claims; ***and***

(b) Preservation, examination and use of records which have been ~~[microphotographed or filmed]~~ ***stored on computer or in a microphotographic, electronic or similar format*** by an insurer. ~~[; and~~

~~(c) Location of a file on a closed claim.~~

~~6.]~~ ***5.*** This section does not require an insurer to allow inspection or reproduction of material regarding which a legal privilege against disclosure has been conferred.

Sec. 3. NRS 616B.027 is hereby amended to read as follows:

616B.027 1. Every insurer shall ~~[provide:~~

~~(a) An]~~ ***:***

(a) Provide an office in this state operated by the insurer or its third-party administrator in which:

(1) A complete file of each claim is ~~[kept;]~~ ***accessible, in accordance with the provisions of NRS 616B.021;***

(2) Persons authorized to act for the insurer and, if necessary, licensed pursuant to chapter 683A of NRS, may receive information related to a claim and provide the services to an employer and his employees required by chapters 616A to 617, inclusive, of NRS; and

(3) An employee or his employer, upon request, is provided with information related to a claim filed by the employee or a copy ***or other reproduction*** of the information from the file for that claim ~~[.~~

~~(b) Statewide,]~~ ***, in accordance with the provisions of NRS 616B.021.***

(b) Provide statewide toll-free telephone service to ~~[that]~~ ***the*** office ***maintained pursuant to paragraph (a)*** or accept collect calls from injured employees.

2. Each private carrier shall provide:

(a) Adequate services to its insured employers in controlling losses; and

(b) Adequate information on the prevention of industrial accidents and occupational diseases.

Sec. 4. NRS 616B.368 is hereby amended to read as follows:

616B.368 1. The board of trustees of an association of self-insured public or private employers is responsible for the money collected and disbursed by the association.

2. The board of trustees shall:

(a) Establish a claims account in a financial institution in this state which is approved by the commissioner and which is federally insured or

insured by a private insurer approved pursuant to NRS 678.755. Except as otherwise provided in subsection 3, at least 75 percent of the annual assessment collected by the association from its members must be deposited in this account to pay:

(1) Claims;

(2) Expenses related to those claims;

(3) The costs associated with the association's policy of excess insurance; and

(4) Assessments, payments and penalties related to the subsequent injury fund and the uninsured employers' claim fund.

(b) Establish an administrative account in a financial institution in this state which is approved by the commissioner and which is federally insured or insured by a private insurer approved pursuant to NRS 678.755. The amount of the annual assessment collected by the association that is not deposited in its claims account must be deposited in this account to pay the administrative expenses of the association.

3. The commissioner may authorize an association to deposit less than 75 percent of its annual assessment in its claims account if the association presents evidence to the satisfaction of the commissioner that:

(a) More than 25 percent of the association's annual assessment is needed to maintain its programs for loss control and occupational safety; and

(b) The association's policy of excess insurance attaches at less than 75 percent.

4. ~~[The]~~ ***Notwithstanding the provisions of chapter 355 of NRS that limit investments of public employers, the*** board of trustees ***of either an association of self-insured private employers or an association of self-insured public employers*** may invest the money of the association not needed to pay the obligations of the association pursuant to chapter 682A of NRS.

5. The commissioner shall review the accounts of an association established pursuant to this section at such times as he deems necessary to ensure compliance with the provisions of this section.

Sec. 5. Chapter 616C of NRS is hereby amended by adding thereto a new section to read as follows:

1. If an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 denies payment for some or all of the services itemized on a statement submitted by a provider of health care on the sole basis that those services were not related to the employee's industrial injury or occupational disease, the insurer, organization for managed care or employer shall, at the same time that it sends notification to the provider of health care of the denial, send a copy of the statement to the injured employee and notify the injured employee that it has denied payment. The notification sent to the injured employee must:

(a) State the relevant amount requested as payment in the statement, that the reason for denying payment is that the services were not related to the industrial injury, and that, pursuant to subsection 2, the injured employee will be responsible for payment of the relevant amount if he

does not, in a timely manner, appeal the denial pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive, or appeals but is not successful.

(b) Include an explanation of the injured employee's right to request a hearing to appeal the denial pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive, and a suitable form for requesting a hearing to appeal the denial.

2. An injured employee who does not, in a timely manner, appeal the denial of payment for the services rendered or, who appeals the denial but is not successful, is responsible for payment of the relevant charges on the itemized statement.

3. To succeed on appeal, the injured employee must show that the:

(a) Services provided were related to the employee's industrial injury or occupational disease; or

(b) Insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 gave prior authorization for the services rendered and did not withdraw that prior authorization before the services of the provider of health care were rendered.

Sec. 6. NRS 616C.135 is hereby amended to read as follows:

616C.135 1. A provider of health care who accepts a patient as a referral for the treatment of an industrial injury or an occupational disease may not charge the patient for any treatment related to the industrial injury or occupational disease, but must charge the insurer. The provider of health care may charge the patient for any ~~[other unrelated services which are requested in writing by the patient.]~~ ***services that are not related to the employee's industrial injury or occupational disease.***

2. The insurer is liable for the charges for approved services ***related to the industrial injury or occupational disease*** if the charges do not exceed:

(a) The fees established in accordance with NRS 616C.260 or the usual fee charged by that person or institution, whichever is less; and

(b) The charges provided for by the contract between the provider of health care and the insurer or the contract between the provider of health care and the organization for managed care.

3. If a provider of health care, an organization for managed care, an insurer or an employer violates the provisions of this section, the administrator shall impose an administrative fine of not more than $250 for each violation.

Sec. 7. This act becomes effective on July 1, 2001.

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