SENATE BILL NO. 99–SENATOR O'CONNELL (BY REQUEST)

FEBRUARY 12, 2001

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes to provisions relating to prompt payment of claims to providers of health care. (BDR 57-132)

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 insurance; revising provisions governing the prompt payment by insurers of approved claims to providers of health care; revising the rate of interest applicable to the late payment of such claims; prohibiting the assessment of fees against providers of health care to be included on a list of providers of health care; establishing an administrative fine against insurers who do not substantially comply with the provisions requiring prompt payment of approved claims to providers 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:

Section 1. NRS 679B.138 is hereby amended to read as follows:

679B.138 1. The commissioner shall adopt regulations which require the use of uniform claim forms and billing codes and the ability to make compatible electronic data transfers for all insurers and administrators authorized to conduct business in this state relating to a health care plan or health insurance or providing or arranging for the provision of health care services, including, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation, a health maintenance organization, a plan for dental care and a prepaid limited health service organization. ***The regulations must include, without limitation, a uniform billing format to be used for the submission of claims to such insurers and administrators.***

2. As used in this section:

(a) "Administrator" has the meaning ascribed to it in NRS 683A.025.

(b) "Health care plan" means a policy, contract, certificate or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Sec. 1.5. NRS 683A.0879 is hereby amended to read as follows:

683A.0879 1. Except as otherwise provided in subsection 2, an administrator shall approve or deny a claim relating to health insurance coverage within 30 days after the administrator receives the claim. If the claim is approved, the administrator shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the administrator shall pay interest on the claim at ~~[the]~~ ***a*** rate of interest ~~[established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the administrator and the provider of health care.]~~ ***equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent.*** The interest must be calculated from 30 days after the date on which the claim is approved until the ***date on which the*** claim is paid.

2. If the administrator requires additional information to determine whether to approve or deny the claim, he shall notify the claimant of his request for the additional information within 20 days after he receives the claim. The administrator shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The administrator shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the administrator shall pay the claim within 30 days after he receives the additional information. If the approved claim is not paid within that period, the administrator shall pay interest on the claim in the manner prescribed in subsection 1.

3. An administrator shall not request a claimant to resubmit information that the claimant has already provided to the administrator, unless the administrator provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. An administrator shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may not be waived.

7. The commissioner may require an administrator to provide evidence which demonstrates that the administrator has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims. If the commissioner determines that an administrator is not in substantial compliance with the requirements set forth in this section, the commissioner may require the administrator to pay an administrative fine in an amount to be determined by the commissioner.

Sec. 2. NRS 689A.035 is hereby amended to read as follows:

689A.035 An insurer ~~[may]~~ ***shall not*** charge a provider of health care a fee to include the name of the provider on a list of providers of health

care given by the insurer to its insureds. ~~[The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the insurer to include the provider on the list.]~~

Sec. 3. NRS 689A.410 is hereby amended to read as follows:

689A.410 1. Except as otherwise provided in subsection 2, an insurer shall approve or deny a claim relating to a policy of health insurance within 30 days after the insurer receives the claim. If the claim is approved, the insurer shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the insurer shall pay interest on the claim at ~~[the]~~ ***a*** rate of interest ~~[established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the insurer and the provider of health care.]~~ ***equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent.*** The interest must be calculated from 30 days after the date on which the claim is approved until the ***date on which the*** claim is paid.

2. If the insurer requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The insurer shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the insurer shall pay interest on the claim in the manner prescribed in subsection 1.

3. An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may not be waived.

7. The commissioner may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims. If the commissioner determines that an insurer is not in substantial compliance with the requirements set forth in this section, the commissioner may require the insurer to pay an administrative fine in an amount to be determined by the commissioner.

Sec. 4. NRS 689B.015 is hereby amended to read as follows:

689B.015 An insurer that issues a policy of group health insurance ~~[may]~~ ***shall not*** charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds. ~~[The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the insurer to include the provider on the list.]~~

Sec. 5. NRS 689B.255 is hereby amended to read as follows:

689B.255 1. Except as otherwise provided in subsection 2, an insurer shall approve or deny a claim relating to a policy of group health insurance or blanket insurance within 30 days after the insurer receives the claim. If the claim is approved, the insurer shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the insurer shall pay interest on the claim at ~~[the]~~ ***a*** rate of interest ~~[established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the insurer and the provider of health care.]~~ ***equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent.*** The interest must be calculated from 30 days after the date on which the claim is approved until the ***date on which the*** claim is paid.

2. If the insurer requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The insurer shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the insurer shall pay interest on the claim in the manner prescribed in subsection 1.

3. An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer provides a legitimate reason for the request and the purpose of the request ~~[in]~~ ***is*** not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may not be waived.

7. The commissioner may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims. If the

commissioner determines that an insurer is not in substantial compliance with the requirements set forth in this section, the commissioner may require the insurer to pay an administrative fine in an amount to be determined by the commissioner.

Sec. 6. NRS 689C.435 is hereby amended to read as follows:

689C.435 A carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group ~~[may]~~ ***shall not*** charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the carrier to its insureds. ~~[The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the carrier to include the provider on the list.]~~

Sec. 7. NRS 689C.485 is hereby amended to read as follows:

689C.485 1. Except as otherwise provided in subsection 2, a carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group shall approve or deny a claim relating to a policy of health insurance within 30 days after the carrier receives the claim. If the claim is approved, the carrier shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the carrier shall pay interest on the claim at ~~[the]~~ ***a*** rate of interest ~~[established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the carrier and the provider of health care.]~~ ***equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent.*** The interest must be calculated from 30 days after the date on which the claim is approved until the ***date on which the*** claim is paid.

2. If the carrier requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The carrier shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The carrier shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the carrier shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the carrier shall pay interest on the claim in the manner prescribed in subsection 1.

3. A carrier shall not request a claimant to resubmit information that the claimant has already provided to the carrier, unless the carrier provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A carrier shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may not be waived.

7. The commissioner may require a carrier to provide evidence which demonstrates that the carrier has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims. If the commissioner determines that a carrier is not in substantial compliance with the requirements set forth in this section, the commissioner may require the carrier to pay an administrative fine in an amount to be determined by the commissioner.

Sec. 8. NRS 695A.095 is hereby amended to read as follows:

695A.095 A society ~~[may]~~ ***shall not*** charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the society to its insureds. ~~[The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the society to include the provider on the list.]~~

Sec. 9. NRS 695B.035 is hereby amended to read as follows:

695B.035 A corporation subject to the provisions of this chapter ~~[may]~~ ***shall not*** charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the corporation to its insureds. ~~[The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the corporation to include the provider on the list.]~~

Sec. 10. NRS 695B.2505 is hereby amended to read as follows:

695B.2505 1. Except as otherwise provided in subsection 2, a corporation subject to the provisions of this chapter shall approve or deny a claim relating to a contract for dental, hospital or medical services within 30 days after the corporation receives the claim. If the claim is approved, the corporation shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the corporation shall pay interest on the claim at ~~[the]~~ ***a*** rate of interest ~~[established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the corporation and the provider of health care.]~~ ***equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent.*** The interest must be calculated from 30 days after the date on which the claim is approved until the ***date on which the*** claim is paid.

2. If the corporation requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The corporation shall notify the provider of dental, hospital or medical services of all the specific reasons for the delay in approving or denying the claim. The corporation shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the corporation shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the corporation shall pay interest on the claim in the manner prescribed in subsection 1.

3. A corporation shall not request a claimant to resubmit information that the claimant has already provided to the corporation, unless the corporation provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A corporation shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may not be waived.

7. The commissioner may require a corporation to provide evidence which demonstrates that the corporation has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims. If the commissioner determines that a corporation is not in substantial compliance with the requirements set forth in this section, the commissioner may require the corporation to pay an administrative fine in an amount to be determined by the commissioner.

Sec. 11. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health maintenance organization shall not:

(a) Enter into any contract or agreement, or make any other arrangements, with a provider for the provision of health care; or

(b) Employ a provider pursuant to a contract, an agreement or any other arrangement to provide health care,

unless the contract, agreement or other arrangement specifically provides that the health maintenance organization and provider agree to the schedule for the payment of claims set forth in NRS 695C.185.

2. Any contract, agreement or other arrangement between a health maintenance organization and a provider that is entered into or renewed on or after the effective date of this act that does not specifically include a provision concerning the schedule for the payment of claims as required by subsection 1 shall be deemed to conform with the requirements of subsection 1 by operation of law.

Sec. 12. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this Title, the provisions of this Title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this Title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.170 to ***695C.180, inclusive, 695C.190 to*** 695C.200, inclusive, 695C.250 and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the state plan for Medicaid or insurance pursuant to the children's health insurance program pursuant to a contract with the division of health care financing and policy of the department of human resources. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 and 695C.1695 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the state plan for Medicaid.

Sec. 13. NRS 695C.055 is hereby amended to read as follows:

695C.055 1. The provisions of NRS 449.465, 679B.158, subsections 2, 4, 18, 19 and 32 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, ~~[and 695G.010 to 695G.260, inclusive,]~~ ***chapter 695G of NRS and section 16 of this act,*** apply to a health maintenance organization.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to insurers, any reference in those sections to "insurer" must be replaced by "health maintenance organization."

Sec. 14. NRS 695C.125 is hereby amended to read as follows:

695C.125 A health maintenance organization ~~[may]~~ ***shall not*** charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the health maintenance organization to its enrollees. ~~[The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the health maintenance organization to include the provider on the list.]~~

Sec. 15. NRS 695C.185 is hereby amended to read as follows:

695C.185 1. Except as otherwise provided in subsection 2, a health maintenance organization shall approve or deny a claim relating to a health care plan within 30 days after the health maintenance organization receives the claim. If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim at ~~[the]~~ ***a*** rate of interest ~~[established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the health maintenance organization and the provider of health care.]~~ ***equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent.*** The interest must be calculated from 30 days after the date on which the claim is approved until the ***date on which the*** claim is paid.

2. If the health maintenance organization requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20

days after it receives the claim. The health maintenance organization shall notify the provider of health care services of all the specific reasons for the delay in approving or denying the claim. The health maintenance organization shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim in the manner prescribed in subsection 1.

3. A health maintenance organization shall not request a claimant to resubmit information that the claimant has already provided to the health maintenance organization, unless the health maintenance organization provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A health maintenance organization shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may not be waived.

7. The commissioner may require a health maintenance organization to provide evidence which demonstrates that the health maintenance organization has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims. If the commissioner determines that a health maintenance organization is not in substantial compliance with the requirements set forth in this section, the commissioner may require the health maintenance organization to pay an administrative fine in an amount to be determined by the commissioner.

Sec. 16. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

A managed care organization that establishes a panel of providers of health care for the purpose of offering health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS shall not charge a provider of health care a fee to include the name of the provider on the panel of providers of health care.

Sec. 17. Chapter 616C of NRS is hereby amended by adding thereto the provisions set forth as sections 18 and 19 of this act.

Sec. 18. ***1. Except as otherwise provided in this section, an insurer shall approve or deny a bill for accident benefits received from a provider of health care within 30 calendar days after the insurer receives the bill. If the bill for accident benefits is approved, the insurer shall pay the bill within 30 calendar days after it is approved. If the approved bill for accident benefits is not paid within that period, the insurer shall pay interest to the provider of health care at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the***

case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 calendar days after the date on which the bill is approved until the date on which the bill is paid.

2. If an insurer needs additional information to determine whether to approve or deny a bill for accident benefits received from a provider of health care, he shall notify the provider of health care of his request for the additional information within 20 calendar days after he receives the bill. The insurer shall notify the provider of health care of all the specific reasons for the delay in approving or denying the bill for accident benefits. Upon the receipt of such a request, the provider of health care shall furnish the additional information to the insurer within 20 calendar days after receiving the request. If the provider of health care fails to furnish the additional information within that period, the provider of health care is not entitled to the payment of interest to which he would otherwise be entitled for the late payment of the bill for accident benefits. The insurer shall approve or deny the bill for accident benefits within 20 calendar days after he receives the additional information. If the bill for accident benefits is approved, the insurer shall pay the bill within 20 calendar days after he receives the additional information. Except as otherwise provided in this subsection, if the approved bill for accident benefits is not paid within that period, the insurer shall pay interest to the provider of health care at the rate set forth in subsection 1. The interest must be calculated from 20 calendar days after the date on which the insurer receives the additional information until the date on which the bill is paid.

3. An insurer shall not request a provider of health care to resubmit information that the provider of health care has previously provided to the insurer, unless the insurer provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the accident benefits, harass the provider of health care or discourage the filing of claims.

4. An insurer shall not pay only a portion of a bill for accident benefits that has been approved and is fully payable.

5. The administrator may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements of this section, including, without limitation, payment within the time required of at least 95 percent of approved accident benefits or at least 90 percent of the total dollar amount of approved accident benefits. If the administrator determines that an insurer is not in substantial compliance with the requirements of this section, the administrator may require the insurer to pay an administrative fine in an amount to be determined by the administrator.

6. The payment of interest provided for in this section for the late payment of an approved bill for accident benefits may not be waived.

7. Payments made by an insurer pursuant to this section are not an admission of liability for the accident benefits or any portion of the accident benefits.

Sec. 19. ***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 or occupational disease 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. 20. NRS 616C.065 is hereby amended to read as follows:

616C.065 1. ~~[Within]~~ ***Except as otherwise provided in section 18 of this act, within*** 30 days after the insurer has been notified of an industrial accident, every insurer shall:

(a) Commence payment of a claim for compensation; or

(b) Deny the claim and notify the claimant and administrator that the claim has been denied.

Payments made by an insurer pursuant to this section are not an admission of liability for the claim or any portion of the claim.

2. If an insurer unreasonably delays or refuses to pay ***that portion of*** the claim ***for compensation that is not required to be paid pursuant to section 18 of this act*** within 30 days after the insurer has been notified of an industrial accident, the insurer shall pay upon order of the administrator an additional amount equal to three times the amount specified in the order as refused or unreasonably delayed. This payment is for the benefit of the

claimant and must be paid to him with the compensation assessed pursuant to chapters 616A to 617, inclusive, of NRS.

Sec. 21. 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. 22. If a different rate of interest has been established pursuant to an express written contract between an administrator, insurer, carrier, corporation or health maintenance organization and a provider of health care, the amendatory provisions of sections 1.5, 3, 5, 7, 10, 11, 15 and 18 of this act, relating to the amount of interest that accrues if an approved claim is not timely paid, apply only to contracts between the administrator, insurer, carrier, corporation or health maintenance organization and the provider of health care that are entered into or renewed on or after the effective date of this act.