

(REPRINTED WITH ADOPTED AMENDMENTS)  
THIRD REPRINT

S.B. 99

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 governing health insurance.  
(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; allowing an employee who is injured or who contracts an occupational disease outside this state to receive compensation from the uninsured employers’ claim fund under certain circumstances; 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.** NRS 679B.138 is hereby amended to read as follows:  
2     679B.138 1. The commissioner shall adopt regulations which require  
3     the use of uniform claim forms and billing codes and the ability to make  
4     compatible electronic data transfers for all insurers and administrators  
5     authorized to conduct business in this state relating to a health care plan or  
6     health insurance or providing or arranging for the provision of health care  
7     services, including, without limitation, an insurer that issues a policy of  
8     health insurance, an insurer that issues a policy of group health insurance, a  
9     carrier serving small employers, a fraternal benefit society, a hospital or  
10    medical service corporation, a health maintenance organization, a plan for  
11    dental care and a prepaid limited health service organization. *The*  
12    *regulations must include, without limitation, a uniform billing format to*  
13    *be used for the submission of claims to such insurers and administrators.*  
14    2. As used in this section:  
15    (a) “Administrator” has the meaning ascribed to it in NRS 683A.025.



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

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

5 683A.0879 1. Except as otherwise provided in subsection 2, an  
6 administrator shall approve or deny a claim relating to health insurance  
7 coverage within 30 days after the administrator receives the claim. If the  
8 claim is approved, the administrator shall pay the claim within 30 days  
9 after it is approved. ~~## Except as otherwise provided in this section, if~~ the  
10 approved claim is not paid within that period, the administrator shall pay  
11 interest on the claim at ~~the~~ a rate of interest ~~established pursuant to NRS~~  
12 ~~99.040 unless a different rate of interest is established pursuant to an~~  
13 ~~express written contract between the administrator and the provider of~~  
14 ~~health care.~~ *equal to the prime rate at the largest bank in Nevada, as*  
15 *ascertained by the commissioner of financial institutions, on January 1*  
16 *or July 1, as the case may be, immediately preceding the date on which*  
17 *the payment was due, plus 6 percent.* The interest must be calculated from  
18 30 days after the date on which the claim is approved until the *date on*  
19 *which the* claim is paid.

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

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

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

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

40 6. *The payment of interest provided for in this section for the late*  
41 *payment of an approved claim may be waived only if the payment was*  
42 *delayed because of an act of God or another cause beyond the control of*  
43 *the administrator.*

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



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1 *not in substantial compliance with the requirements set forth in this*  
2 *section, the commissioner may require the administrator to pay an*  
3 *administrative fine in an amount to be determined by the commissioner.*

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

5 689A.035 An insurer ~~may~~ **shall not** charge a provider of health care  
6 a fee to include the name of the provider on a list of providers of health  
7 care given by the insurer to its insureds. ~~{The amount of the fee must be~~  
8 ~~reasonable and must not exceed an amount that is directly related to the~~  
9 ~~administrative costs of the insurer to include the provider on the list.}~~

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

11 689A.410 1. Except as otherwise provided in subsection 2, an insurer  
12 shall approve or deny a claim relating to a policy of health insurance within  
13 30 days after the insurer receives the claim. If the claim is approved, the  
14 insurer shall pay the claim within 30 days after it is approved. ~~{If}~~ **Except**  
15 **as otherwise provided in this section, if** the approved claim is not paid  
16 within that period, the insurer shall pay interest on the claim at ~~{the}~~ **a** rate  
17 of interest ~~{established pursuant to NRS 99.040 unless a different rate of~~  
18 ~~interest is established pursuant to an express written contract between the~~  
19 ~~insurer and the provider of health care.}~~ **equal to the prime rate at the**  
20 **largest bank in Nevada, as ascertained by the commissioner of financial**  
21 **institutions, on January 1 or July 1, as the case may be, immediately**  
22 **preceding the date on which the payment was due, plus 6 percent.** The  
23 interest must be calculated from 30 days after the date on which the claim  
24 is approved until the **date on which the** claim is paid.

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

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

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

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

44 **6. The payment of interest provided for in this section for the late**  
45 **payment of an approved claim may be waived only if the payment was**  
46 **delayed because of an act of God or another cause beyond the control of**  
47 **the insurer.**

48 **7. The commissioner may require an insurer to provide evidence**  
49 **which demonstrates that the insurer has substantially complied with the**



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1 *requirements set forth in this section, including, without limitation,*  
2 *payment within 30 days of at least 95 percent of approved claims or at*  
3 *least 90 percent of the total dollar amount for approved claims. If the*  
4 *commissioner determines that an insurer is not in substantial compliance*  
5 *with the requirements set forth in this section, the commissioner may*  
6 *require the insurer to pay an administrative fine in an amount to be*  
7 *determined by the commissioner.*

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

9 689B.015 An insurer that issues a policy of group health insurance  
10 ~~may~~ **shall not** charge a provider of health care a fee to include the name  
11 of the provider on a list of providers of health care given by the insurer to  
12 its insureds. ~~The amount of the fee must be reasonable and must not~~  
13 ~~exceed an amount that is directly related to the administrative costs of the~~  
14 ~~insurer to include the provider on the list.~~

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

16 689B.255 1. Except as otherwise provided in subsection 2, an insurer  
17 shall approve or deny a claim relating to a policy of group health insurance  
18 or blanket insurance within 30 days after the insurer receives the claim. If  
19 the claim is approved, the insurer shall pay the claim within 30 days after it  
20 is approved. ~~##~~ **Except as otherwise provided in this section, if** the  
21 approved claim is not paid within that period, the insurer shall pay interest  
22 on the claim at ~~the~~ **a** rate of interest ~~established pursuant to NRS 99.040~~  
23 ~~unless a different rate of interest is established pursuant to an express~~  
24 ~~written contract between the insurer and the provider of health care.~~ **equal**  
25 **to the prime rate at the largest bank in Nevada, as ascertained by the**  
26 **commissioner of financial institutions, on January 1 or July 1, as the**  
27 **case may be, immediately preceding the date on which the payment was**  
28 **due, plus 6 percent.** The interest must be calculated from 30 days after the  
29 date on which the claim is approved until the **date on which the** claim is  
30 paid.

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

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

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

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



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1     6. *The payment of interest provided for in this section for the late*  
2 *payment of an approved claim may be waived only if the payment was*  
3 *delayed because of an act of God or another cause beyond the control of*  
4 *the insurer.*

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

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

15     689C.435 A carrier serving small employers and a carrier that offers a  
16 contract to a voluntary purchasing group ~~may~~ **shall not** charge a provider  
17 of health care a fee to include the name of the provider on a list of  
18 providers of health care given by the carrier to its insureds. ~~The amount of~~  
19 ~~the fee must be reasonable and must not exceed an amount that is directly~~  
20 ~~related to the administrative costs of the carrier to include the provider on~~  
21 ~~the list.~~

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

23     689C.485 1. Except as otherwise provided in subsection 2, a carrier  
24 serving small employers and a carrier that offers a contract to a voluntary  
25 purchasing group shall approve or deny a claim relating to a policy of  
26 health insurance within 30 days after the carrier receives the claim. If the  
27 claim is approved, the carrier shall pay the claim within 30 days after it is  
28 approved. ~~It~~ **Except as otherwise provided in this section, if** the  
29 approved claim is not paid within that period, the carrier shall pay interest  
30 on the claim at ~~the~~ **a** rate of interest ~~established pursuant to NRS 99.040~~  
31 ~~unless a different rate of interest is established pursuant to an express~~  
32 ~~written contract between the carrier and the provider of health care.~~ **equal**  
33 **to the prime rate at the largest bank in Nevada, as ascertained by the**  
34 **commissioner of financial institutions, on January 1 or July 1, as the**  
35 **case may be, immediately preceding the date on which the payment was**  
36 **due, plus 6 percent.** The interest must be calculated from 30 days after the  
37 date on which the claim is approved until the **date on which the** claim is  
38 paid.

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



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

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

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

10 *6. The payment of interest provided for in this section for the late*  
11 *payment of an approved claim may be waived only if the payment was*  
12 *delayed because of an act of God or another cause beyond the control of*  
13 *the carrier.*

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

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

24 695A.095 A society ~~may~~ **shall not** charge a provider of health care a  
25 fee to include the name of the provider on a list of providers of health care  
26 given by the society to its insureds. ~~{The amount of the fee must be~~  
27 ~~reasonable and must not exceed an amount that is directly related to the~~  
28 ~~administrative costs of the society to include the provider on the list.}~~

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

30 695B.035 A corporation subject to the provisions of this chapter ~~may~~  
31 **shall not** charge a provider of health care a fee to include the name of the  
32 provider on a list of providers of health care given by the corporation to its  
33 insureds. ~~{The amount of the fee must be reasonable and must not exceed~~  
34 ~~an amount that is directly related to the administrative costs of the~~  
35 ~~corporation to include the provider on the list.}~~

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

37 695B.2505 1. Except as otherwise provided in subsection 2, a  
38 corporation subject to the provisions of this chapter shall approve or deny a  
39 claim relating to a contract for dental, hospital or medical services within  
40 30 days after the corporation receives the claim. If the claim is approved,  
41 the corporation shall pay the claim within 30 days after it is approved. ~~{If}~~  
42 **Except as otherwise provided in this section, if** the approved claim is not  
43 paid within that period, the corporation shall pay interest on the claim at  
44 ~~{the}~~ **a** rate of interest ~~{established pursuant to NRS 99.040 unless a~~  
45 ~~different rate of interest is established pursuant to an express written~~  
46 ~~contract between the corporation and the provider of health care.}~~ **equal to**  
47 **the prime rate at the largest bank in Nevada, as ascertained by the**  
48 **commissioner of financial institutions, on January 1 or July 1, as the**  
49 **case may be, immediately preceding the date on which the payment was**



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1 *due, plus 6 percent.* The interest must be calculated from 30 days after the  
2 date on which the claim is approved until the *date on which the* claim is  
3 paid.

4 2. If the corporation requires additional information to determine  
5 whether to approve or deny the claim, it shall notify the claimant of its  
6 request for the additional information within 20 days after it receives the  
7 claim. The corporation shall notify the provider of dental, hospital or  
8 medical services of all the specific reasons for the delay in approving or  
9 denying the claim. The corporation shall approve or deny the claim within  
10 30 days after receiving the additional information. If the claim is approved,  
11 the corporation shall pay the claim within 30 days after it receives the  
12 additional information. If the approved claim is not paid within that period,  
13 the corporation shall pay interest on the claim in the manner prescribed in  
14 subsection 1.

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

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

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

24 6. *The payment of interest provided for in this section for the late*  
25 *payment of an approved claim may be waived only if the payment was*  
26 *delayed because of an act of God or another cause beyond the control of*  
27 *the corporation.*

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

37 **Sec. 11.** Chapter 695C of NRS is hereby amended by adding thereto  
38 the provisions set forth as sections 11.3 and 11.7 of this act.

39 **Sec. 11.3. 1.** *A health maintenance organization shall not:*

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

42 *(b) Employ a provider pursuant to a contract, an agreement or any*  
43 *other arrangement to provide health care,*  
44 *unless the contract, agreement or other arrangement specifically*  
45 *provides that the health maintenance organization and provider agree to*  
46 *the schedule for the payment of claims set forth in NRS 695C.185.*

47 2. *Any contract, agreement or other arrangement between a health*  
48 *maintenance organization and a provider that is entered into or renewed*  
49 *on or after October 1, 2001, that does not specifically include a provision*





1 *concerning the schedule for the payment of claims as required by*  
2 *subsection 1 shall be deemed to conform with the requirements of*  
3 *subsection 1 by operation of law.*

4 **Sec. 11.7.** *Any contract or other agreement entered into or renewed*  
5 *by a health maintenance organization on or after October 1, 2001:*

6 *1. To provide health care services through managed care to*  
7 *recipients of Medicaid under the state plan for Medicaid; or*

8 *2. With the division of health care financing and policy of the*  
9 *department of human resources to provide insurance pursuant to the*  
10 *children's health insurance program,*  
11 *must require the health maintenance organization to pay interest to a*  
12 *provider of health care services on a claim that is not paid within the*  
13 *time provided in the contract or agreement at a rate of interest equal to*  
14 *the prime rate at the largest bank in Nevada, as ascertained by the*  
15 *commissioner of financial institutions, on January 1 or July 1, as the*  
16 *case may be, immediately preceding the date on which the payment was*  
17 *due, plus 6 percent. The interest must be calculated from 30 days after*  
18 *the date on which the claim is approved until the date on which the claim*  
19 *is paid.*

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

21 695C.050 1. Except as otherwise provided in this chapter or in  
22 specific provisions of this Title, the provisions of this Title are not  
23 applicable to any health maintenance organization granted a certificate of  
24 authority under this chapter. This provision does not apply to an insurer  
25 licensed and regulated pursuant to this Title except with respect to its  
26 activities as a health maintenance organization authorized and regulated  
27 pursuant to this chapter.

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

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

35 4. The provisions of NRS 695C.110, 695C.170 to 695C.200, inclusive,  
36 ~~and~~ sections 19 and 20 of ~~this act.~~ *Senate Bill No. 2 of this session,*  
37 *section 11.3 of this act and* NRS 695C.250 and 695C.265 do not apply to a  
38 health maintenance organization that provides health care services through  
39 managed care to recipients of Medicaid under the state plan for Medicaid  
40 or insurance pursuant to the children's health insurance program pursuant  
41 to a contract with the division of health care financing and policy of the  
42 department of human resources. This subsection does not exempt a health  
43 maintenance organization from any provision of this chapter for services  
44 provided pursuant to any other contract.

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





1     **Sec. 13.** NRS 695C.055 is hereby amended to read as follows:  
2     695C.055 1. The provisions of NRS 449.465, 679B.158, subsections  
3     2, 4, 18, 19 and 32 of NRS 680B.010, NRS 680B.025 to 680B.060,  
4     inclusive, ~~and 695G.010 to 695G.260, inclusive,~~ *chapter 695G of NRS*  
5     *and section 16 of this act*, apply to a health maintenance organization.

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

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

10    695C.125 A health maintenance organization ~~may~~ *shall not* charge a  
11    provider of health care a fee to include the name of the provider on a list of  
12    providers of health care given by the health maintenance organization to its  
13    enrollees. ~~[The amount of the fee must be reasonable and must not exceed~~  
14    ~~an amount that is directly related to the administrative costs of the health~~  
15    ~~maintenance organization to include the provider on the list.]~~

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

17    695C.185 1. Except as otherwise provided in subsection 2, a health  
18    maintenance organization shall approve or deny a claim relating to a health  
19    care plan within 30 days after the health maintenance organization receives  
20    the claim. If the claim is approved, the health maintenance organization  
21    shall pay the claim within 30 days after it is approved. ~~##~~ *Except as*  
22    *otherwise provided in this section, if* the approved claim is not paid within  
23    that period, the health maintenance organization shall pay interest on the  
24    claim at ~~the~~ *a* rate of interest ~~established pursuant to NRS 99.040 unless~~  
25    ~~a different rate of interest is established pursuant to an express written~~  
26    ~~contract between the health maintenance organization and the provider of~~  
27    ~~health care,~~ *equal to the prime rate at the largest bank in Nevada, as*  
28    *ascertained by the commissioner of financial institutions, on January 1*  
29    *or July 1, as the case may be, immediately preceding the date on which*  
30    *the payment was due, plus 6 percent.* The interest must be calculated from  
31    30 days after the date on which the claim is approved until the *date on*  
32    *which the* claim is paid.

33    2. If the health maintenance organization requires additional  
34    information to determine whether to approve or deny the claim, it shall  
35    notify the claimant of its request for the additional information within 20  
36    days after it receives the claim. The health maintenance organization shall  
37    notify the provider of health care services of all the specific reasons for the  
38    delay in approving or denying the claim. The health maintenance  
39    organization shall approve or deny the claim within 30 days after receiving  
40    the additional information. If the claim is approved, the health maintenance  
41    organization shall pay the claim within 30 days after it receives the  
42    additional information. If the approved claim is not paid within that period,  
43    the health maintenance organization shall pay interest on the claim in the  
44    manner prescribed in subsection 1.

45    3. A health maintenance organization shall not request a claimant to  
46    resubmit information that the claimant has already provided to the health  
47    maintenance organization, unless the health maintenance organization  
48    provides a legitimate reason for the request and the purpose of the request



1 is not to delay the payment of the claim, harass the claimant or discourage  
2 the filing of claims.

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

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

7 *6. The payment of interest provided for in this section for the late*  
8 *payment of an approved claim may be waived only if the payment was*  
9 *delayed because of an act of God or another cause beyond the control of*  
10 *the health maintenance organization.*

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

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

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

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

30 **Sec. 18. 1.** *Except as otherwise provided in this section, an insurer*  
31 *shall approve or deny a bill for accident benefits received from a provider*  
32 *of health care within 30 calendar days after the insurer receives the bill.*  
33 *If the bill for accident benefits is approved, the insurer shall pay the bill*  
34 *within 30 calendar days after it is approved. Except as otherwise provided*  
35 *in this section, if the approved bill for accident benefits is not paid within*  
36 *that period, the insurer shall pay interest to the provider of health care at*  
37 *a rate of interest equal to the prime rate at the largest bank in Nevada, as*  
38 *ascertained by the commissioner of financial institutions, on January 1*  
39 *or July 1, as the case may be, immediately preceding the date on which*  
40 *the payment was due, plus 6 percent. The interest must be calculated*  
41 *from 30 calendar days after the date on which the bill is approved until*  
42 *the date on which the bill is paid.*

43 **2.** *If an insurer needs additional information to determine whether to*  
44 *approve or deny a bill for accident benefits received from a provider of*  
45 *health care, he shall notify the provider of health care of his request for*  
46 *the additional information within 20 calendar days after he receives the*  
47 *bill. The insurer shall notify the provider of health care of all the specific*  
48 *reasons for the delay in approving or denying the bill for accident*  
49 *benefits. Upon the receipt of such a request, the provider of health care*



1 shall furnish the additional information to the insurer within 20 calendar  
2 days after receiving the request. If the provider of health care fails to  
3 furnish the additional information within that period, the provider of  
4 health care is not entitled to the payment of interest to which he would  
5 otherwise be entitled for the late payment of the bill for accident benefits.  
6 The insurer shall approve or deny the bill for accident benefits within 20  
7 calendar days after he receives the additional information. If the bill for  
8 accident benefits is approved, the insurer shall pay the bill within 20  
9 calendar days after he receives the additional information. Except as  
10 otherwise provided in this subsection, if the approved bill for accident  
11 benefits is not paid within that period, the insurer shall pay interest to the  
12 provider of health care at the rate set forth in subsection 1. The interest  
13 must be calculated from 20 calendar days after the date on which the  
14 insurer receives the additional information until the date on which the  
15 bill is paid.

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

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

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

33 6. The payment of interest provided for in this section for the late  
34 payment of an approved claim may be waived only if the payment was  
35 delayed because of an act of God or another cause beyond the control of  
36 the insurer.

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

40 **Sec. 19. 1.** If an insurer, organization for managed care or  
41 employer who provides accident benefits for injured employees pursuant  
42 to NRS 616C.265 denies payment for some or all of the services itemized  
43 on a statement submitted by a provider of health care on the sole basis  
44 that those services were not related to the employee's industrial injury or  
45 occupational disease, the insurer, organization for managed care or  
46 employer shall, at the same time that it sends notification to the provider  
47 of health care of the denial, send a copy of the statement to the injured  
48 employee and notify the injured employee that it has denied payment.  
49 The notification sent to the injured employee must:



1 (a) State the relevant amount requested as payment in the statement,  
2 that the reason for denying payment is that the services were not related  
3 to the industrial injury or occupational disease and that, pursuant to  
4 subsection 2, the injured employee will be responsible for payment of the  
5 relevant amount if he does not, in a timely manner, appeal the denial  
6 pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive, or  
7 appeals but is not successful.

8 (b) Include an explanation of the injured employee's right to request a  
9 hearing to appeal the denial pursuant to NRS 616C.305 and 616C.315 to  
10 616C.385, inclusive, and a suitable form for requesting a hearing to  
11 appeal the denial.

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

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

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

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

24 **Sec. 20.** NRS 616C.065 is hereby amended to read as follows:

25 616C.065 1. ~~Within~~ *Except as otherwise provided in section 18 of*  
26 *this act, within* 30 days after the insurer has been notified of an industrial  
27 accident, every insurer shall:

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

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

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

33 2. ~~HH~~ *Except as otherwise provided in this subsection, if* an insurer  
34 unreasonably delays or refuses to pay the claim within 30 days after the  
35 insurer has been notified of an industrial accident, the insurer shall pay  
36 upon order of the administrator an additional amount equal to three times  
37 the amount specified in the order as refused or unreasonably delayed. This  
38 payment is for the benefit of the claimant and must be paid to him with the  
39 compensation assessed pursuant to chapters 616A to 617, inclusive, of  
40 NRS. *The provisions of this section do not apply to the payment of a bill*  
41 *for accident benefits that is governed by the provisions of section 18 of*  
42 *this act.*

43 **Sec. 21.** NRS 616C.135 is hereby amended to read as follows:

44 616C.135 1. A provider of health care who accepts a patient as a  
45 referral for the treatment of an industrial injury or an occupational disease  
46 may not charge the patient for any treatment related to the industrial injury  
47 or occupational disease, but must charge the insurer. The provider of health  
48 care may charge the patient for any ~~other unrelated services which are~~



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~~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.** NRS 616C.220 is hereby amended to read as follows:

616C.220 1. The division shall designate one:

(a) Third-party administrator who has a valid certificate issued by the commissioner pursuant to NRS 683A.085; or

(b) Insurer, other than a self-insured employer or association of self-insured public or private employers, to administer claims against the uninsured employers' claim fund. The designation must be made pursuant to reasonable competitive bidding procedures established by the administrator.

2. ~~{An}~~ *Except as otherwise provided in this subsection, an* employee may receive compensation from the uninsured employers' claim fund if:

(a) He was hired in this state or he is regularly employed in this state;

(b) He suffers an accident or injury ~~{in this state}~~ which arises out of and in the course of his employment ~~{}~~ :

*(1) In this state; or*

*(2) While on temporary assignment outside the state for a period of not more than 12 months;*

(c) He files a claim for compensation with the division; and

(d) He makes an irrevocable assignment to the division of a right to be subrogated to the rights of the injured employee pursuant to NRS 616C.215.

*An employee who suffers an accident or injury while on temporary assignment outside the state is not eligible to receive compensation from the uninsured employers' claim fund unless he has been denied workers' compensation in the state in which the accident or injury occurred.*

3. If the division receives a claim pursuant to subsection 2, the division shall immediately notify the employer of the claim.

4. For the purposes of this section, the employer has the burden of proving that he provided mandatory industrial insurance coverage for the employee or that he was not required to maintain industrial insurance for the employee.

5. Any employer who has failed to provide mandatory coverage required by the provisions of chapters 616A to 616D, inclusive, of NRS is liable for all payments made on his behalf, including any benefits, administrative costs or attorney's fees paid from the uninsured employers' claim fund or incurred by the division.



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1 6. The division:

2 (a) May recover from the employer the payments made by the division  
3 that are described in subsection 5 and any accrued interest by bringing a  
4 civil action in district court.

5 (b) In any civil action brought against the employer, is not required to  
6 prove that negligent conduct by the employer was the cause of the  
7 employee's injury.

8 (c) May enter into a contract with any person to assist in the collection  
9 of any liability of an uninsured employer.

10 (d) In lieu of a civil action, may enter into an agreement or settlement  
11 regarding the collection of any liability of an uninsured employer.

12 7. The division shall:

13 (a) Determine whether the employer was insured within 30 days after  
14 receiving notice of the claim from the employee.

15 (b) Assign the claim to the third-party administrator or insurer  
16 designated pursuant to subsection 1 for administration and payment of  
17 compensation.

18 Upon determining whether the claim is accepted or denied, the designated  
19 third-party administrator or insurer shall notify the injured employee, the  
20 named employer and the division of its determination.

21 8. Upon demonstration of the:

22 (a) Costs incurred by the designated third-party administrator or insurer  
23 to administer the claim or pay compensation to the injured employee; or

24 (b) Amount that the designated third-party administrator or insurer will  
25 pay for administrative expenses or compensation to the injured employee  
26 and that such amounts are justified by the circumstances of the  
27 claim,

28 the division shall authorize payment from the uninsured employers' claim  
29 fund.

30 9. Any party aggrieved by a determination regarding the  
31 administration of an assigned claim or a determination made by the  
32 division or by the designated third-party administrator or insurer regarding  
33 any claim made pursuant to this section may appeal that determination  
34 within 60 days after the determination is rendered to the hearings division  
35 of the department of administration in the manner provided by NRS  
36 616C.305 and 616C.315 to 616C.385, inclusive.

37 10. All insurers shall bear a proportionate amount of a claim made  
38 pursuant to chapters 616A to 616D, inclusive, of NRS, and are entitled to a  
39 proportionate amount of any collection made pursuant to this section as an  
40 offset against future liabilities.

41 11. An uninsured employer is liable for the interest on any amount  
42 paid on his claims from the uninsured employers' claim fund. The interest  
43 must be calculated at a rate equal to the prime rate at the largest bank in  
44 Nevada, as ascertained by the commissioner of financial institutions, on  
45 January 1 or July 1, as the case may be, immediately preceding the date of  
46 the claim, plus 3 percent, compounded monthly, from the date the claim is  
47 paid from the fund until payment is received by the division from the  
48 employer.



1 12. Attorney's fees recoverable by the division pursuant to this section  
2 must be:

3 (a) If a private attorney is retained by the division, paid at the usual and  
4 customary rate for that attorney.

5 (b) If the attorney is an employee of the division, paid at the rate  
6 established by regulations adopted by the division.

7 Any money collected must be deposited to the uninsured employers' claim  
8 fund.

9 13. In addition to any other liabilities provided for in this section, the  
10 administrator may impose an administrative fine of not more than \$10,000  
11 against an employer if the employer fails to provide mandatory coverage  
12 required by the provisions of chapters 616A to 616D, inclusive, of NRS.

13 **Sec. 23.** NRS 617.401 is hereby amended to read as follows:

14 617.401 1. The division shall designate one:

15 (a) Third-party administrator who has a valid certificate issued by the  
16 commissioner pursuant to NRS 683A.085; or

17 (b) Insurer, other than a self-insured employer or association of self-  
18 insured public or private employers,  
19 to administer claims against the uninsured employers' claim fund. The  
20 designation must be made pursuant to reasonable competitive bidding  
21 procedures established by the administrator.

22 2. ~~1. An~~ *Except as otherwise provided in this subsection, an* employee  
23 may receive compensation from the uninsured employers' claim fund if:

24 (a) He was hired in this state or he is regularly employed in this state;

25 (b) He contracts an occupational disease ~~as a result of work performed~~  
26 ~~in this state;~~ *that arose out of and in the course of employment:*

27 *(1) In this state; or*

28 *(2) While on temporary assignment outside the state for a period of*  
29 *not more than 12 months;*

30 (c) He files a claim for compensation with the division; and

31 (d) He makes an irrevocable assignment to the division of a right to be  
32 subrogated to the rights of the employee pursuant to NRS 616C.215.

33 *An employee who contracts an occupational disease that arose out of and*  
34 *in the course of employment while on temporary assignment outside the*  
35 *state is not entitled to receive compensation from the uninsured*  
36 *employers' claim fund unless he has been denied workers' compensation*  
37 *in the state in which the disease was contracted.*

38 3. If the division receives a claim pursuant to subsection 2, the division  
39 shall immediately notify the employer of the claim.

40 4. For the purposes of this section, the employer has the burden of  
41 proving that he provided mandatory coverage for occupational diseases for  
42 the employee or that he was not required to maintain industrial insurance  
43 for the employee.

44 5. Any employer who has failed to provide mandatory coverage  
45 required by the provisions of this chapter is liable for all payments made on  
46 his behalf, including, but not limited to, any benefits, administrative costs  
47 or attorney's fees paid from the uninsured employers' claim fund or  
48 incurred by the division.





1     6. The division:

2     (a) May recover from the employer the payments made by the division  
3 that are described in subsection 5 and any accrued interest by bringing a  
4 civil action in district court.

5     (b) In any civil action brought against the employer, is not required to  
6 prove that negligent conduct by the employer was the cause of the  
7 occupational disease.

8     (c) May enter into a contract with any person to assist in the collection  
9 of any liability of an uninsured employer.

10    (d) In lieu of a civil action, may enter into an agreement or settlement  
11 regarding the collection of any liability of an uninsured employer.

12    7. The division shall:

13    (a) Determine whether the employer was insured within 30 days after  
14 receiving the claim from the employee.

15    (b) Assign the claim to the third-party administrator or insurer  
16 designated pursuant to subsection 1 for administration and payment of  
17 compensation.

18 Upon determining whether the claim is accepted or denied, the designated  
19 third-party administrator or insurer shall notify the injured employee, the  
20 named employer and the division of its determination.

21    8. Upon demonstration of the:

22    (a) Costs incurred by the designated third-party administrator or insurer  
23 to administer the claim or pay compensation to the injured employee; or

24    (b) Amount that the designated third-party administrator or insurer will  
25 pay for administrative expenses or compensation to the injured employee  
26 and that such amounts are justified by the circumstances of the  
27 claim,

28 the division shall authorize payment from the uninsured employers' claim  
29 fund.

30    9. Any party aggrieved by a determination regarding the  
31 administration of an assigned claim or a determination made by the  
32 division or by the designated third-party administrator or insurer regarding  
33 any claim made pursuant to this section may appeal that determination  
34 within 60 days after the determination is rendered to the hearings division  
35 of the department of administration in the manner provided by NRS  
36 616C.305 and 616C.315 to 616C.385, inclusive.

37    10. All insurers shall bear a proportionate amount of a claim made  
38 pursuant to this chapter, and are entitled to a proportionate amount of any  
39 collection made pursuant to this section as an offset against future  
40 liabilities.

41    11. An uninsured employer is liable for the interest on any amount  
42 paid on his claims from the uninsured employers' claim fund. The interest  
43 must be calculated at a rate equal to the prime rate at the largest bank in  
44 Nevada, as ascertained by the commissioner of financial institutions, on  
45 January 1 or July 1, as the case may be, immediately preceding the date of  
46 the claim, plus 3 percent, compounded monthly, from the date the claim is  
47 paid from the fund until payment is received by the division from the  
48 employer.



12. Attorney's fees recoverable by the division pursuant to this section must be:

(a) If a private attorney is retained by the division, paid at the usual and customary rate for that attorney.

(b) If the attorney is an employee of the division, paid at the rate established by regulations adopted by the division.

Any money collected must be deposited to the uninsured employers' claim fund.

13. In addition to any other liabilities provided for in this section, the administrator may impose an administrative fine of not more than \$10,000 against an employer if the employer fails to provide mandatory coverage required by the provisions of this chapter.

**Sec. 23.5.** Section 10 of Assembly Bill No. 338 of this session is hereby amended to read as follows:

Sec. 10. 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 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. *A provider of health care may accept payment from an injured employee who is paying in protest pursuant to section 5 of this act for treatment or other services that the injured employee alleges are related to the industrial injury or occupational disease.*

4. 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. 24.** 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, 11.3, 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 October 1, 2001.



- 1     **Sec. 25.** 1. This section, sections 1 to 11.7, inclusive, and 13 to 24,  
2 inclusive, of this act become effective on October 1, 2001.  
3     2. Section 12 of this act becomes effective at 12:01 a.m. on October 1,  
4 2001.

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