

SENATE BILL NO. 280—COMMITTEE ON COMMERCE AND LABOR
(ON BEHALF OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE)

MARCH 13, 2007

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions related to patients' bills.
(BDR 54-303)

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 health care; providing that certain health care bills must be provided to a patient within a specified period of time; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

1 Under existing law, a provider of health care must give each patient a bill
2 which itemizes any services, equipment, supplies or medicine provided. (NRS
3 629.071) The existing statute specifies that the bill must be provided in a timely
4 manner after the charges are incurred. (NRS 629.071) Various individual
5 practitioners are subject to this requirement, as are licensed hospitals when acting
6 as an employer of such practitioners. (NRS 629.071)
7 This bill replaces the provision requiring the bill to be provided in a timely
8 manner with a requirement that the patient's bill be provided within 120 days after
9 certain specified events. Additionally, licensed hospitals are no longer subject to the
10 requirement, as the definition of "provider of health care" has been revised
11 specifically for this provision.

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

1 **Section 1.** NRS 629.071 is hereby amended to read as follows:
2 629.071 **1.** Each provider of health care shall, on his bill to a
3 patient, itemize all charges for services, equipment, supplies and
4 medicines provided for the patient in terms which the patient is able
5 to understand.



2. The bill must be ~~timely~~ provided *to the patient at no additional cost* after the charge is incurred ~~at no additional cost to the patient.~~ and not more than 120 days after the later of:

(a) The date that the provider of health care receives the correct billing information to contact the patient;

(b) If the patient provides information to the provider of health care concerning coverage by a health care insurer or the provider of health care otherwise determines that the patient has such coverage, the date that the provider of health care receives documentation from the patient's health care insurer indicating its final determination of the extent of the benefits, if any, provided by the health care insurer; and

(c) If the patient does not provide information to the provider of health care concerning coverage by a health care insurer, the date that the provider of health care determines that the patient does not have coverage by a health care insurer.

3. As used in this section:

(a) "Health care insurer" means any insurer that provides any type of policy, contract, agreement or plan providing health coverage or benefits in accordance with state or federal law, including, without limitation, a provider of industrial insurance.

(b) "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, dentist, licensed nurse, dispensing optician, optometrist, practitioner of respiratory care, registered physical therapist, podiatric physician, licensed psychologist, licensed marriage and family therapist, chiropractor, athletic trainer, doctor of Oriental medicine in any form, medical laboratory director or technician, or pharmacist.

