Committee Action:
Do Pass _____
Amend & Do Pass _____
Other _____

Assembly Committee on Commerce and Labor

This measure may be considered for action during today's work session.

ASSEMBLY BILL 290

Revises provisions relating to prior authorization for medical or dental care under health insurance plans. (BDR 57-861)

Sponsored By:	Assemblymembers Nguyen, Considine, and Nadeem, et al.
Date Heard:	April 4, 2025
Fiscal Notes:	Effect on Local Government: May have Fiscal Impact. Effect on the State: Yes. CONTAINS UNFUNDED MANDATE

Assembly Bill 290 imposes certain requirements governing prior authorization for medical or dental care by health insurers, including Medicaid, the Children's Health Insurance Program, and insurance for public employees, including:

- Establishing certain requirements for a health insurer's procedure for obtaining prior authorization, including, without limitation, a requirement that such a procedure include a list of the specific goods and services for which the insurer requires prior authorization and the clinical review criteria used by the insurer to evaluate a request for prior authorization;
- Revising the period of time in which an insurer is required to take action on a request for prior authorization to 24 hours in the case of care that is urgent and 5 days in the case of care that is not urgent;
- Prohibiting an adverse determination on a request for prior authorization except in certain circumstances;
- Requiring an insurer, upon making an adverse determination on a request for prior authorization, to transmit certain information to the insured to whom the request pertains, including information relating to the right to appeal the adverse determination;
- Providing that a request for prior authorization that has been approved by an insurer remains valid for 12 months and requiring an insurer, for the first 90 days of the coverage period for a new insured, to honor a request for prior authorization that has been approved by the previous insurer under certain conditions;
- Prohibiting an insurer from requiring prior authorization for covered emergency services; and
- Requiring an insurer to annually publish on its Internet website information relating to requests for prior authorization that have been processed by the insurer during the immediately preceding year and submit similar information to the Commissioner of Insurance.

Amendments:

Assemblymember Nguyen proposes the following amendments:

- Amend the bill to add Assemblymembers Yurek and Brown-May as primary sponsors; Assemblymembers Anderson, Cole, D'Silva, González, Goulding, Karris, Koenig, Kasama, and Mosca as co-sponsors; and Senators Neal and Taylor as joint sponsors;

- Amend Section 3 of the bill to revise the definition of the term "adverse determination";
- Amend Sections 4 and 28 to revise the definition of the term "emergency services";
- Amend Section 7 to revise the definition of the term "insured";
- Delete Sections 9, 10, and 33 to delete definitions for the terms "network," "network plan," and "urgent health care," respectively;
- Amend Section 13 to revise provisions governing the making of an adverse determination on a request for prior authorization by a health carrier, including, without limitation, adding certain provisions governing the use of an artificial intelligence system or automated decision tool to process requests for prior authorization;
- Amend Section 14 to revise limitations on a health carrier as they relate to a request for prior authorization which has previously been approved;
- Amend Section 15 to eliminate provisions prohibiting a health carrier from denying coverage for any covered emergency services that are medically necessary;
- Amend Section 17 to require certain health carriers to compile and transmit to the Commissioner of Insurance certain specified information relating to requests for prior authorization and revise the information relating to requests for prior authorization, which a health carrier must publish on its Internet website;
- Amend Section 18 to eliminate certain reporting requirements governing health carriers and to revise the requirements for the Commissioner to compile and transmit a report summarizing certain information to the Director of the Legislative Counsel Bureau for transmittal to the Joint Interim Standing Committee on Health and Human Services and the Joint Interim Standing Committee on Commerce and Labor;
- Amend Section 19 to revise the length of the period of time in which a health carrier is required to take action on a request for prior authorization and to revise provisions governing the amendment by a health carrier of its procedures for obtaining prior authorization;
- Amend Section 25 to revise the applicability of certain provisions governing prior authorization as they relate to the provision of services to a recipient of Medicaid or the Children's Health Insurance Program;
- Amend Section 30 to revise the definition of the term "medically necessary";
- Amend Section 31 to revise the definition of the term "provider of health care";
- Amend Section 34 to revise provisions governing the amendment by the Department of Health and Human Services of its procedures for obtaining prior authorization;
- Amend Section 35 to revise the length of the period of time in which the Department is required to take action on certain requests for prior authorization, including, without limitation, removing the words "non-urgent" from paragraph (a) of subsection 1 and paragraph (c)(1) of subsection 2;
- Amend Section 36 to revise provisions governing the making of an adverse determination on a request for prior authorization by the Department;

- Amend Section 37 to revise limitations on the Department as they relate to a request for prior authorization which has previously been approved; and

- Amend subsection 1 of Section 39 to eliminate provisions providing that, if the Department violates certain provisions of this bill with respect to a particular request for prior authorization, the request shall be deemed approved.

Assemblymember Marzola proposes the following amendments:

- Amend Section 5 and subsection 5 of Section 37 to provide that the term "health carrier" includes a utilization review organization as defined in *Nevada Revised Statutes* (NRS) 695G.085; and

- Repeal NRS 687B.723 and 695D.2153.

DUY NGUYEN
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EIGHTY-THIRD SESSION

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April 9th, 2025

RE: AB 290 Conceptual Amendment

PROPOSED CONCEPTUAL AMENDMENT TO AB290

INTENT: Addition of Sponsors and revision of original bill language

Amendment to add the following Primary Sponsors:
Assemblymember Toby Yurek
Assemblymember Tracy Brown-May

Amendment to add the following Co-Sponsors:
Assemblymember Natha Anderson
Assemblymember Lisa Cole
Assemblymember Reuben D'Silva
Assemblymember Cecelia González
Assemblymember Heather Goulding
Assemblymember Venise Karris
Assemblymember Gregory S. Koenig
Assemblymember Heidi Kasama
Assemblymember Erica Mosca

Amendment to add the following Joint Sponsors:
Senator Dina Neal
Senator Angela D. Taylor

EXPLANATION: Matter in ***bolded italics*** is new; matter between brackets ~~*[omitted materials]*~~ is material to be omitted.

Sec. 3.

Adverse determination" means a determination by a health carrier that an admission, ~~*availability of care, continued stay*~~ ***or other medical care or dental care that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care***

or effectiveness, and the requested care or service or payment for the care or service is therefore denied ~~*, reduced or terminated*~~***.***

Sec. 4.

2. ***Serious jeopardy to the death of a fetus*** ~~*an unborn child*~~ ***of the insured;***

Sec. 7. ***"Insured" has the meaning ascribed in NRS 679.540*** ~~*means a policyholder, subscriber, enrollee or other person covered by a health carrier.*~~

Sec. 9. ~~*"Network" means a defined set of providers of health care who are under contract with a health carrier to provide health care services pursuant to a network plan offered or issued by the health carrier.*~~

Sec. 10. ~~*"Network plan" means a contract or policy of insurance offered by a health carrier under which the financing and delivery of medical or dental care is provided, in whole or in part, through a defined set of providers under contract with the health carrier.*~~

Sec. 13. ***1. A health carrier shall not make an adverse determination on a request for prior authorization unless:***

(a) The adverse determination is made by a physician or, for dental care, a dentist, who:

(1) Holds an unrestricted license to practice medicine or dentistry, as applicable, in any state or territory of the United States;

~~*(2) Is the same or similar specialty of a physician or dentist, as applicable, who typically manages or treats the medical or dental condition or provides the health or dental are involved in the request; and*~~

(3). Has knowledge, training, or experience treating or managing the medical or dental condition involved in the request; and

(b) The adverse determination is reviewed and affirmed by:

(1) ~~*The*~~ ***A medical director of the health carrier or a similar employee who is in charge of*** ~~*the*~~ ***medical operations of the health carrier; or***

2. If a physician or dentist described in paragraph (a) of subsection 1 is considering making an adverse determination on a request for prior authorization on the basis that the medical or dental care involved in the request is not medically necessary, the health carrier that received the request shall:

(a). ~~*Immediately*~~ ***notify the provider of health care, or the persons designated by the provider of health care to manage requests for prior authorization, who submitted the request that the medical necessity of the requested care is being questioned by the health carrier; and***

(b) Offer the provider of health care who submitted the prior authorization request or a provider of health care that has the knowledge and ability to provide additional information that works with the provider of health care that submitted the prior authorization request, an opportunity to speak with the physician or dentist, as applicable, over the telephone or by videoconference to discuss the clinical issues involved in the request before the physician or dentist renders an initial determination on the request.

5. A health carrier shall not uphold on appeal an adverse determination pertaining to a request for prior authorization unless the decision on the appeal is made by a physician or, for dental care, a dentist, who:

(a) Holds an unrestricted license to practice medicine or dentistry, as applicable, in any state or territory of the United States;

~~*(b)Evaluates and treats patients in his or her capacity as an actively practicing physician or dentist, as applicable;*~~

~~*(c) Is the same or similar specialty as a physician or dentist, as applicable, who typically manages or treats the medical or dental condition or provides the medical or dental care involved in the request;*~~

(e) Has knowledge, training, or experience treating or managing the medical or dental condition involved in the request;

(f) Was not involved in making the adverse determination that is the subject of the appeal;

(g) Considers all known clinical aspects of the medical or dental care involved in the request; and

(h) Is employed by or contracted with the health carrier to:

(1) Participate in the network of the health carrier in his or her capacity as a practicing physician or dentist, as applicable; or

(2) ~~Solely~~ Primarily make determinations on reviews or appeals of adverse determinations.

6. If a health carrier utilizes an artificial intelligence system or automated decision tool to process requests for prior authorization, the health carrier shall make available, in a place that is readily accessible and conspicuous to insureds and the public:

(a) A statement that the health carrier utilizes an artificial intelligence system or automated decision tool to process requests for prior authorization.

(b) A general description of how the artificial intelligence system or automated decision tool works; and

(c) A description of the specific types of information or data utilized by the artificial intelligence system or automated decision tool to generate an outcome.

7. Except as otherwise provided in subsection 3, a health carrier shall not utilize or employ an artificial intelligence system or automated decision tool to:

(a) Make an adverse determination on a request for prior authorization; or

(b) Terminate, reduce, or modify coverage for medical or dental care that was previously approved by the health carrier.

8. A health carrier may utilize or employ an artificial intelligence system or automated decision tool for a purpose described in subsection 2 if, when the artificial intelligence system or automated decision tool generates an outcome on a request for prior authorization, the request is independently reviewed by a physician or, for a request involving dental care, a dentist, who:

(a) Holds an unrestricted license to practice medicine or dentistry, as applicable, in any state or territory of the United States; and

(b) Has knowledge, training, or experience treating or managing the medical or dental condition involved in the request.

9. As used in this section:

(a) "Artificial intelligence system" means a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments.

(b) "Automated decision tool" means an automated or computerized system that is specifically developed or modified to make, or to be a controlling factor in making, consequential decisions.

Sec. 14.

1. If a health carrier approves a request for prior authorization, the approval remains valid until ~~12~~6 months after the date on which the request is approved if the process has been initiated to carry out the service approved.

2. A health carrier shall not revoke or impose an additional limit, condition or restriction on a request for prior authorization that the health carrier has previously approved ~~unless:~~

~~(a) The care at issue in the request was not provided to the insured within 90 business days after the health carrier received the request;~~

(a~~b~~) The health carrier determines that an insured or a provider of health care procured the approval by fraud or material misrepresentation; ~~or~~

(b~~c~~) The health carrier determines that the care at issue in the request was not covered by the health carrier at the time the care was provided; or~~.~~

(c) The coverage period has ended and the insured enrolls in a plan with lower overall cost share for the procedure.

3. A health carrier that has approved a request for prior authorization shall not deny or refuse to promptly pay a claim for the approved medical or dental care unless the health carrier determines that the insured or provider of health care procured the prior authorization by fraud or material misrepresentation. ~~The claim must be paid at the same rate that the health carrier is contractually obligated to or would ordinarily pay a provider of health care for providing the specific type of care that was approved and provided to the insured.~~

4. Within the first 90 days of the coverage period for an insured, a health carrier shall honor a request for prior authorization that has been approved by a health carrier or other entity that previously provided the insured with coverage for medical or dental care if:

(a). The approval was issued within the ~~12~~6 months immediately preceding the first day of the coverage period under the current contract or policy of insurance; ~~and~~

(b). The insured or the insured's provider of healthcare transmitted complete documentation of such approvals in a timely manner; and

(c~~b~~). The specific medical or dental care included within the request is not affirmatively excluded under the terms and conditions of the contract or policy of insurance issued by the health carrier.

5. Except as otherwise provided in this subsection, if a health carrier approves a request for prior authorization for a continuous course of treatment that relates to a chronic or long-term condition which is specifically identified in the request for prior authorization, the approval remains valid for 12 months from the date on which the health carrier approved the request. A health carrier may require additional prior authorization for medical or dental care that represents a substantial deviation from the course of treatment indicated in the previous request for prior authorization that was approved by the health carrier.

6. As used in this section, "coverage period" means the current term of a contract or policy of insurance issued by a health carrier.

Sec. 15.

~~*3. A health carrier shall not deny coverage for any emergency services covered by the health carrier that are medically necessary. Emergency services are presumed to be medically necessary if, within 72 hours after an insured is admitted to receive emergency services, the insured's provider of health care transmits to the health carrier a certification, that the condition of the insured required emergency services. The health carrier may rebut that presumption by establishing, by clear and convincing evidence, that the emergency services were not medically necessary.*~~

Sec. 17.

1. On or before March 1 of each calendar year, a health carrier that requires an insured to get prior authorization shall compile and transmit to the Commissioner, in a form prescribed by the Commissioner, and publish on an Internet website maintained by the health carrier in an easily accessible format the following information ~~*for the immediately preceding calendar year*~~***, in aggregated form*** ~~*for*~~ ***of all urgent and non-urgent requests for prior authorization received by the insurer during the*** ~~*immediately preceding*~~ ***previous benefit plan year and disaggregated in accordance with subsection 2:***

(a) The number ~~*percentage*~~ ***of initial prior authorization requests*** ~~*for prior authorization*~~ ***for medical or dental care in this State that were approved and received an adverse determination upon initial review;***

~~*(b) The percentage of requests for prior authorization for medical or dental care in this State that resulted in an adverse determination upon initial review;*~~

(c) The ~~*percentage*~~ ***number of the adverse determinations described in paragraph (b) that were appealed;***

(d) The ~~*percentage*~~ ***number of appeals*** ~~*of adverse determinations*~~ ***described in paragraph (c) that resulted in a reversal of the adverse determination;***

(e) The top five ~~*most common*~~ ***reasons for*** ~~*the*~~ ***adverse determination decisions in paragraph (b); and***

(f) The average time between submission and response for an initial request for prior authorization ~~*for medical or dental care in this State*~~***, and between submission and response for an appeal of an adverse determination for medical or dental care in this State*** ~~*and the resolution of the request*~~***.***

3. A health carrier shall also publish on an Internet website maintained by the health carrier a report containing the following information the specific items and services for which the health carrier requires prior authorization and, for each item or service, the date on which prior authorization for that item or service became required for contracts or policies issued or delivered in this State and the date on which that requirement was listed on the Internet website of the health carrier pursuant to subsection 6 of NRS 687B.225.

4. A health carrier shall not include individually identifiable health information in the information published pursuant to subsection 1.

Sec. 18.

1. On or before May 1 of each even-numbered year, the Commissioner shall:

(a) Compile a report summarizing the information submitted to the Commissioner pursuant to subsection 1 during the immediately preceding biennium and providing recommendations for legislation to improve the process for obtaining prior authorization; and

(b) Submit the report and all information provided to the Commissioner pursuant to subsection 1 to the Director of the Legislative Counsel Bureau for transmittal to the Joint Interim Standing Committee on Health and Human Services and the Joint Interim Standing Committee on Commerce and Labor.

2. A health carrier shall not include individually identifiable health information in a report published pursuant to subsection 1.

~~*1. On or before March 1 of each calendar year, a health carrier shall compile and transmit to the Commissioner, in a form prescribed by the Commissioner, and publish on an Internet website maintained by the health carrier a report containing the following information:*~~

~~*(a) The specific goods and services for which the health carrier requires prior authorization and, for each good or service:*~~

~~*(1) The date on which prior authorization for that good or service became required for contracts or policies issued or delivered in this State and the date on which that requirement was listed on the Internet website of the health carrier pursuant to subsection 6 of NRS 687B.225;*~~

~~*(2) The number of requests for prior authorization received by the health carrier during the immediately preceding calendar year for the provision of the good or service to insureds in this State;*~~

~~*(3) The number and percentage of the requests listed pursuant to subparagraph (2) that were approved;*~~

~~*(4) The number and percentage of the requests listed pursuant to subparagraph (2) that resulted in adverse determinations; and*~~

~~*(5) The number of appeals from adverse determinations during the immediately preceding calendar year and the percentage of those appeals that were reversed on appeal by the health carrier.*~~

~~*(b) For all requests for prior authorization for non-urgent health or dental care received by the health carrier during the immediately preceding calendar year, the average and median time between:*~~

~~*(1) The health carrier receiving a request for prior authorization and the health carrier approving or making an adverse determination on the request; and*~~

~~*(2) The submission of an appeal of an adverse determination on a request for prior authorization and the resolution of the appeal.*~~

~~*(c) For all requests for prior authorization for urgent health care received by the health carrier during the immediately preceding calendar year, the average and median time between:*~~

~~*(1) The health carrier receiving a request for prior authorization and the health carrier approving or making an adverse determination on the request; and*~~

~~*(2) The submission of an appeal of an adverse determination on a request for prior authorization and the resolution of the appeal.*~~

Sec. 19. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.0418, 689A.0437, 689A.044, 689A.0445, 689A.0459, 689B.031, 689B.0312, 689B.0313,689B.0315, 689B.0317, 689B.0319, 689B.0374, 689B.0378, 689C.1665, 689C.1671, 689C.1675, 689C.1676, 695A.1843, 695A.1856, 695A.1865, 695A.1874, 695B.1912, 695B.1913, 695B.1914, 695B.1919, 695B.19197, 695B.1924, 695B.1925, 695B.1942, 695C.1696, 695C.1699, 695C.1713, 695C.1735, 695C.1737, 695C.1743, 695C.1745, 695C.1751, 695G.170, 695G.1705, 695G.171, 695G.1714, 695G.1715, 695G.1719 and 695G.177, ***and section 15 of this act,*** any contract ~~[for group, blanket or individual health]~~ ***or policy of*** insurance ~~[or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care]~~ ***issued by a health carrier*** which provides for payment of a certain part of medical or dental care may require the insured ~~[or member]~~ to obtain prior authorization for that care from the ~~[insurer or organization. The insurer or organization]~~ ***health carrier in a manner consistent with this section and sections 2 to 18, inclusive, of this act.***

2. A health carrier that requires an insured to obtain prior authorization shall:

(a) File its procedure for obtaining ~~[approval of care]~~ ***prior authorization*** pursuant to this section, ***including***~~, without limitation,~~ ***a list of the*** ~~*specific goods*~~ ***items and services for which the health carrier requires prior authorization and***

the clinical review criteria used by the health carrier to evaluate requests for prior authorization, for approval by the Commissioner. ~~[; and]~~

(b) Unless a shorter time period is prescribed by a specific statute, including, without limitation, NRS 689A.0446, 689B.0361, 689C.1688, 695A.1859, 695B.19087, 695C.16932 and 695G.1703, ~~[respond to]~~ ***and except as otherwise provided by paragraph (c), approve or make an adverse determination on*** any request for ~~[approval by the insured or member]~~ ***prior authorization submitted by or on behalf of the insured*** pursuant to this section ~~[within 20 days after it receives the request.]~~ ***and notify the insured and his or her provider of health care of the approval or adverse determination:***

(1) For non-urgent medical or dental care, within ~~5~~ ***7 calendar days after receiving the request.***

(2) For urgent health care, within ~~24~~***48 hours after receiving the Request.***

(c) If the health carrier requires additional, medically relevant information or documentation in order to adequately evaluate a request for prior authorization:

(1) Notify the insured and the provider of health care who submitted the request within the applicable amount of time described in paragraph (b) that additional information is required to evaluate the request;

(2) Include within the notification sent pursuant to subparagraph (1) a description, with reasonable specificity, of the information that the health carrier requires to make a determination on the request for prior authorization; and

(3) Approve or make an adverse determination on the request:

(I) For non-urgent medical or dental care, within ~~5~~***7 days after receiving the information.***

(II) For urgent health care, within ~~24~~***48 hours after receiving the information.***

~~[2.]~~ ***3.*** The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

~~*4. If a health carrier seeks to amend its procedure for obtaining prior authorization, including, without limitation, changing the goods and services for which the health carrier requires prior authorization or changing the clinical review criteria used by the health carrier, the health carrier:*~~

~~*(a) Must file a request to amend the procedure for approval by the Commissioner.*~~

~~*(b) May not allow the amended procedure to take effect until:*~~

~~*(1) The Commissioner notifies the health carrier that the request is approved; and*~~

~~*(2) The health carrier satisfies the requirements of subsection 5 after the health carrier receives a notice of approval from the Commissioner.*~~

~~*5. A change to a health carrier's procedure for obtaining prior authorization may not take effect until:*~~

~~*(a) The health carrier transmits a notice that contains a summary of the changes to the procedure to each of its insureds and providers of health care who participate in the network of the health carrier;*~~

~~*(b) The health carrier updates the information published on its Internet website pursuant to subsection 6 to reflect the amended procedure for obtaining prior authorization and the date on which the amended procedure takes effect; and*~~

~~*(c) At least 60 days have passed after the later of:*~~

~~*(1) The date on which the health carrier transmitted the notice to its insureds and providers of health care who participate in the network of the health carrier pursuant to paragraph (a); or*~~

~~*(2) The date on which the health carrier updated the information published on its Internet website pursuant to paragraph (b).*~~

6. A health carrier shall publish its procedures for obtaining prior authorization,

including, without limitation, the clinical review criteria, on its Internet website:

(a) Using clear language that is understandable to an ordinary layperson, where practicable; and

(b) In a place that is readily accessible and conspicuous to insureds and the public.

7. A health carrier shall not deny a claim based on the failure of an insured to obtain prior authorization for medical or dental care if the procedure for obtaining prior authorization established by the health carrier did not require the insured to obtain prior authorization for that medical or dental care on the date that the medical or dental care was provided to the insured.

8. As used in this section, "clinical review criteria" means any written screening procedure, decision abstract, clinical protocol or practice guideline used by the health carrier to determine the necessity and appropriateness of medical or dental care.

Sec. 23. NRS. 287.04335 is hereby amended to read as follows:

287.04335. If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 439.581 to 439.597, inclusive, 686A.135, ***paragraphs (b) and (c) of subsection 2 and subsections 1, 3, 5, 6 and 7 of NRS 687B.225***, 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, ***and sections 2 to ~~18~~19, inclusive, of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 25.

1. The provisions of sections 26 to 41, inclusive, of this act and any policies developed pursuant thereto do ~~not~~ apply to the delivery of services to recipients of Medicaid or the Children's Health Insurance Program through managed care in accordance with NRS 422.273, except that section 36, subsection 4 applies as required by federal law.

2. ***The provisions of NRS 687B.225 and sections 2 to 18, inclusive, of this act and any policies developed pursuant thereto do not apply to a health maintenance organization or other managed care organization that enters into a contract with the Department or the Division pursuant to NRS 422.273 to provide health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program.*** ~~*A health maintenance organization or other managed care organization that enters into a contract with the Department or the Division pursuant to NRS 422.273 to provide health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program shall comply with NRS 687B.225 and sections 2 to 18, inclusive, of this act.*~~

Sec. 28.

2. Serious jeopardy to the health of a fetus ~~an unborn child~~ of the recipient;

Sec. 30. ***"Medically necessary" has the meaning ascribed to it in NRS 695G.055 or as otherwise defined and approved by federal law as it applies to Medicaid and the Children's Health Insurance Program, as applicable.***

Sec. 31. ***"Provider of health care" has the meaning ascribed to it in NRS~~695G.070~~ 422.490.***

Sec. 33. ~~*"Urgent health care":*~~

~~*1. Means health care that, in the opinion of a provider of health care with knowledge of a recipient's medical condition, if not rendered to the recipient within 48 hours could:*~~

~~*(a) Seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function; or*~~

~~*(b) Subject the recipient to severe pain that cannot be adequately managed without receiving such care.*~~

~~*2. Does not include emergency services.*~~

Sec. 34.

3. ***If the Department amends the procedure for obtaining prior authorization adopted pursuant to subsection 1, including, without limitation, changing the goods and services for which the Department requires prior authorization or changing the clinical* review criteria used by the Department, the Department shall:**

(a) ~~*Transmit a notice containing a summary of the changes made to the procedure to each recipient and each provider of goods or services under Medicaid or the Children's Health Insurance Program, as applicable*~~ ***Follow existing procedures for the adoption of regulations pursuant to NRS 422.2369 as it relates to changes in prior authorization regulations;*** and

(b) Update the information published on its Internet website pursuant to subsection 2 to reflect the amended procedure for obtaining prior authorization and the date on which the amended procedure takes effect.

4. A change to the Department's procedure for obtaining prior authorization may not take effect until ~~*60 days have passed after the later of*~~ the requirements of subsection 3 of this subpart are met:

~~*(a) The date on which the Department transmitted the notice to recipients and providers of goods or services under Medicaid or the Children's Health Insurance Program, as applicable, pursuant to paragraph (a) of subsection 3; or*~~

~~*(b) The date on which the Department updated the information published on its Internet website pursuant to paragraph (b) of subsection 3.*~~

Sec. 35.

1. ***Unless a shorter time period is prescribed by a specific statute, and except as otherwise provided in subsection 2, and except for requests for Personal Care Services, 1915(c) waiver services and 1915(i) State Plan services, the Department, with respect to Medicaid and the Children's Health Insurance Program, shall approve or make an adverse determination on a request for prior authorization except for prior authorization requests relating to drugs submitted by or on behalf of a recipient and notify the recipient and his or her provider of health care of the approval or adverse determination:***

(a) For non-urgent medical or dental care, within ~~*5*~~ ***7 calendar days after receiving the request.***

~~*(b) For urgent health care, within 24 hours after receiving the request.*~~

2. If the Department requires additional, medically relevant information or documentation in order to adequately evaluate a request for prior authorization, except for prior authorization requests relating to drugs, the Department shall:

(c) Approve or make an adverse determination on the request:

(1) For non-urgent medical or dental care, within ~~*5*~~ ***7 calendar days after receiving the information.***

~~*(2) For urgent health care, within 24 hours after receiving the information.*~~

Sec. 36. 1. The Department, with respect to Medicaid and the Children's Health Insurance Program, shall not make an adverse determination on a request for prior authorization unless the adverse determination is made by a physician, a pharmacist, or, for a request relating to dental care, a dentist, who:

(a) Holds an unrestricted license to practice medicine, ~~or~~ Dentistry or pharmacy, as applicable, in any state or territory of the United States; and

(b) ~~I~~is ***making determinations on a request for medical or dental care which falls within their scope of practice and, to the extent feasible and practicable,*** of the same or similar specialty as a physician, ***pharmacist*** or dentist, as applicable, who typically manages or treats the medical or dental condition or provides the medical or dental care involved in the request.~~; and~~

~~(c) Has experience treating or managing the medical or dental condition involved in the request.~~

~~2. If a physician or dentist described in subsection 1 is considering making an adverse determination on a request for prior authorization on the basis that the medical or dental care involved in the request is not medically necessary, the Department shall:~~

~~(a) Immediately notify the provider of health care who submitted the request that the medical necessity of the requested care is being questioned by the Department; and~~

~~(b) Offer the provider of health care an opportunity to speak with the physician or dentist, as applicable, over the telephone or by videoconference to discuss the clinical issues involved in the request before the physician or dentist renders an initial determination on the request.~~

4. ***The Department shall*** ~~establish a process that allows a recipient to appeal an adverse determination on a request for prior authorization. The process must allow for the clear resolution of each appeal within a reasonable time.~~ ***follow the appeals process pursuant to NRS 422.275 to 422.280, inclusive, when a recipient requests to appeal an adverse determination on a request for prior authorization.***

5. ***The Department shall provide a licensed medical professional, which may include the Department's Medicaid Medical Director as available, at the request of the assigned Hearing Officer, to review an adverse determination under appeal to provide clinical input and expertise.*** ~~not uphold on appeal an adverse determination pertaining to a request for prior authorization unless the decision on the appeal is made by a physician, or, for an appeal relating to dental care, a dentist, who:~~

~~(a) Holds an unrestricted license to practice medicine or dentistry, as applicable, in any state or territory of the United States;~~

~~(b) Evaluates and treats patients in his or her capacity as an actively practicing physician or dentist, as applicable;~~

~~(c) Is of the same or similar specialty as a physician or dentist, as applicable, who typically manages or treats the medical or dental condition or provides the medical or dental care involved in the request;~~

~~(d) Has experience treating or managing the medical or dental condition involved in the request;~~

~~(e) Was not involved in making the adverse determination that is the subject of the appeal;~~

~~(f) Considers all known clinical aspects of the medical or dental care involved in the request; and~~

~~(g) Is employed by or contracted with the Department solely to make determinations on appeals of adverse determinations.~~

Sec. 37. ***1. If the Department approves a request for prior authorization, the approval remains valid until 12 months after the date on which the request is approved, or the length of time permitted under federal law.***

3. If the Department has approved a request for prior authorization, the Department shall not deny or refuse to promptly pay a clean claim for the approved medical or dental care unless the claim is submitted outside established timeframes for timely claim submission, or the claim is not submitted in accordance with nationally recognized standard methods of processing claims and federal guidelines, or the Department determines that the recipient or provider of health care procured the prior authorization by fraud or material misrepresentation. The claim must be paid at the same rate that the Department is contractually obligated to or would ordinarily pay a provider of health care for providing the specific type of care that was approved and provided to the recipient.

~~*4. Within the first 90 days that a recipient is enrolled in Medicaid or the Children's Health Insurance Program, as applicable, the Department shall honor a request for prior authorization that has been approved by a health carrier or other entity that previously provided the recipient with coverage for medical or dental care if:*~~

~~*(a) The approval was issued within the 12 months immediately preceding the first day of the enrollment of the recipient; and*~~

~~*(b) The specific medical or dental care included within the request is not affirmatively excluded under the terms and conditions of Medicaid or the Children's Health Insurance Program, as applicable.*~~

~~*5. As used in this section, "health carrier" has the meaning ascribed to it in NRS 695G.024 and includes, without limitation, an organization for dental care.*~~

Sec. 39. 1. ~~*If the Department violates sections 34 to 38, inclusive, of this act with respect to a particular request for prior authorization, the request shall be deemed approved.*~~

2. Nothing in sections 34 to 38, inclusive, of this act shall be construed to require the Department to provide coverage:

(a) For medical or dental care that, regardless of whether such care is medically necessary, would not be a covered benefit under the terms and conditions of Medicaid or the Children's Health Insurance Program, as applicable; or

(b) To a person who is not a recipient or is not otherwise eligible to receive coverage under Medicaid or the Children's Health Insurance Program, as applicable, on the date on which medical or dental care is provided to the person.

Sec. 42. NRS 422.403 is hereby amended to read as follows:

422.403 1. The Department shall, by regulation, establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs.

2. The Drug Use Review Board shall:

(a) Advise the Department concerning the use by the Medicaid program of step therapy and prior authorization for prescription drugs;

(b) Develop step therapy protocols and prior authorization policies and procedures ***that comply with the provisions of sections*** ~~*26*~~***40 to 41, inclusive, of this act*** *for use by the Medicaid program for prescription drugs; and*

(c) Review and approve, based on clinical evidence and best clinical practice guidelines and without consideration of the cost of the prescription drugs being considered, step therapy protocols used by the Medicaid program for prescription drugs.