PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R132-03

September 30, 2003

EXPLANATION – Matter in ***italics*** is new; matter in brackets ~~[omitted material]~~ is material to be omitted.

AUTHORITY: §§1-3, NRS 679B.130 and section 2 of Assembly Bill No. 79 of the 72nd Session of the Nevada Legislature, chapter 138, Statutes of Nevada 2003, at page 722; §4, NRS 679B.130 and section 20 of Assembly Bill No. 79 of the 72nd Session of the Nevada Legislature, chapter 138, Statutes of Nevada 2003, at page 779.

Section 1. NAC 695F.610 is hereby amended to read as follows:

695F.610 To obtain approval of a system for resolving complaints of enrollees concerning limited health services covered by an organization from the Commissioner as required pursuant to NAC 695F.600, an organization must:

1. Demonstrate that the system will resolve oral and written complaints concerning:

(a) Payment or reimbursement for covered limited health services;

(b) The availability, delivery or quality of covered limited health services, including, without limitation, adverse determinations made pursuant to utilization review; and

(c) The terms and conditions of the evidences of coverage of enrollees.

2. ***Demonstrate that the system will include the external review of a final adverse determination.***

3. Submit to the Division:

(a) The name and title of the employee responsible for the system;

(b) A description of the procedure used to notify an enrollee of the decision regarding his complaint; and

(c) A copy of the explanation of rights and procedures which is to be provided to enrollees pursuant to NAC 695F.620.

Sec. 2. NAC 695F.620 is hereby amended to read as follows:

695F.620 1. ~~[Following]~~ ***After*** approval by the Commissioner, each organization that issues an evidence of coverage in this state shall provide ***a*** written notice to an enrollee, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the enrollee to file a written complaint. Such ***a*** notice must be provided to an enrollee:

(a) At the time he receives his evidence of coverage;

(b) Any time that the organization denies coverage of a limited health service or limits coverage of a limited health service to an enrollee; and

(c) Any other time deemed necessary by the Commissioner.

2. ~~[Any time that]~~ ***If*** an organization denies coverage of a limited health service to an enrollee, it shall notify the enrollee in writing of:

(a) The reason for denying coverage of the limited health service;

(b) The criteria by which the organization determines whether to authorize or deny coverage of the limited health service; ~~[and]~~

(c) His right to ~~[file]~~ ***:***

(1) File a written complaint ~~[.]~~ ***and the procedure for filing such a complaint;***

(2) Appeal a final adverse determination pursuant to sections 21 to 28, inclusive, of Assembly Bill No. 79 of the 72nd Session of the Nevada Legislature, chapter 138, Statutes of Nevada 2003, at page 780;

(3) Receive an expedited external review of a final adverse determination if the managed care organization receives proof from the insured's provider of health care that

failure to proceed in an expedited manner may jeopardize the life or health of the insured, including notification of the procedure for requesting the expedited external review; and

(4) Receive assistance from any person, including an attorney, for an external review of a final adverse determination; and

(d) The telephone number of the Office for Consumer Health Assistance.

3. A written notice which is approved by the Commissioner shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

Sec. 3. NAC 695G.100 is hereby amended to read as follows:

695G.100 To obtain approval of a system for resolving complaints of insureds from the Commissioner as required pursuant to NRS 695G.200, a managed care organization must ***:*** ~~[submit]~~

1. Demonstrate that the system will include the external review of a final adverse determination.

2. Submit to the Division:

~~[1.]~~ ***(a)*** The name and title of the employee responsible for the system;

~~[2.]~~ ***(b)*** A description of the procedure used to notify an insured of the decision regarding his complaint; and

~~[3.]~~ ***(c)*** A copy of the explanation of rights and procedures which is to be provided to insureds pursuant to NRS 695G.230.

Sec. 4. NAC 695C.055 is hereby repealed.

TEXT OF REPEALED SECTION

695C.055 "Medically necessary" defined. "Medically necessary" means services determined by an organization to be appropriate and necessary and required, not merely for the sake of convenience, according to generally accepted principles of medical practice, for the diagnosis or direct care and treatment of an illness or injury.