ASSEMBLY BILL NO. 202–ASSEMBLYMEMBER BROWN-MAY

PREFILED FEBRUARY 3, 2025

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to claims for dental care. (BDR 57-573)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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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 certain definitions for the purposes of certain coverage for health care services; revising provisions governing the circumstances under which a managed care organization is not required to authorize coverage of a health care service; revising the applicability of certain provisions requiring certain insurers to establish a system of procedures for resolving complaints of insured persons and providing for the external review of an adverse determination to include certain insurers that issue policies or certificates that provide only dental coverage; revising the information which a health carrier is required to provide in a notice of an adverse determination; authorizing a dentist of a covered person to submit to the Office for Consumer Health Assistance in the Department of Health and Human Services a request for an external review of an adverse determination; requiring an independent review organization to notify the dentist of a covered person and a health carrier of certain information and the determination and reasons of the independent review organization; requiring a decision of an independent review organization to be based, in part, on certain documentary evidence, including any recommendation of the dentist of the insured; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires each managed care organization to authorize coverage of a health care service that has been recommended for an insured by a provider of health care acting within the scope of his or her practice if that service is covered by the health care plan of the insured unless the decision not to authorize coverage is made by a physician who satisfies certain conditions. (NRS 695G.150) **Section 2** of this bill provides that a managed care organization is also not required to authorize coverage if the decision not to authorize coverage is made by a dentist who satisfies certain conditions.

Existing law: (1) requires a managed care organization to establish a system of procedures for resolving complaints of a person who is insured by a managed care organization; and (2) provides for the external review of an adverse determination by a managed care organization. (NRS 695G.200-695G.310) The requirement for the establishment of a system of procedures for resolving complaints and the provisions setting forth procedures for the external review of an adverse determination also apply to insurers that issue certain policies, plans, contracts and coverage for health insurance in this State that provide, deliver, arrange for, pay for or reimburse costs of health care through managed care, including: (1) certain health insurance provided through a plan of self-insurance for officers and employees of this State; (2) individual health insurance; (3) group health insurance; (4) health benefit plans of small employers; (5) contracts for hospital or medical services; (6) health care plans issued by health maintenance organizations; and (7) evidence of coverage issued by prepaid limited health service organizations. (NRS 287.04335, 689A.745, 689B.0285, 689C.156, 695B.380, 695C.260, 695F.230) Existing law exempts a policy or certificate that provides only dental coverage from these provisions. (NRS 695G.243) **Section 3** of this bill provides that the requirement for the establishment of a system of procedures for resolving complaints and the provisions setting forth procedures for the external review of an adverse determination apply to a policy or certificate that provides only dental coverage.

Existing law requires a health carrier to notify certain persons, including a covered person and his or her treating physician, of: (1) an adverse determination relating to a request for the provision of or payment for a health care service or course of treatment; and (2) certain information which must be included in such a notice, including the ability to file a request for an expedited external review if, among other conditions, the insured's treating physician makes certain written certifications relating to the recommended or requested health care service or treatment. (NRS 695G.245) **Section 4** of this bill provides that a dentist may make the required written certifications.

Existing law authorizes a covered person, a physician of a covered person or an authorized representative to submit a request to the Office for Consumer Health Assistance in the Department of Health and Human Services for an external review of an adverse determination. (NRS 695G.251) **Section 5** of this bill authorizes a dentist of a covered person to submit such a request.

Existing law requires an independent review organization that receives a request for an external review to: (1) notify the covered person, the physician of the covered person and the health carrier if any additional information is required to conduct the review; (2) forward to the health carrier any information received from a covered person or the physician of a covered person; and (3) notify the covered person, the physician of the covered person, the authorized representative of the covered person and the health carrier of its determination and reasons therefor. (NRS 695G.261) **Section 6** of this bill requires the independent review organization to also: (1) notify the dentist of the covered person if any additional information is required to conduct the review; (2) forward to the health carrier any information

received from the dentist of a covered person; and (3) notify the dentist of the covered person of its determination and reasons therefor.

Existing law requires an independent review organization to notify a covered person, the physician of the covered person, the authorized representative, if any, and the health carrier by telephone and in writing after completing its external review. (NRS 695G.271) **Section 7** of this bill requires an independent review organization to notify the dentist of a covered person, if applicable.

Existing law sets forth the process by which an external review of an adverse determination must be conducted. (NRS 695G.275) **Section 8** of this bill revises provisions setting forth that process to provide a covered person's treating dentist with the same powers and duties with respect to that process as a covered person's treating physician.

Existing law requires the decision of an independent review organization concerning a request for an external review to be based, in part, on documentary evidence, including any recommendation of the physician of the insured. (NRS 695G.280) **Section 9** of this bill requires that documentary evidence to include any recommendation of the dentist of the insured.

Existing law provides a clinical peer who conducts or participates in an external review of an adverse determination immunity from liability for certain damages relating to the external review under certain circumstances. (NRS 695G.290) **Section 1** of this bill revises the definition of "clinical peer" to include certain dentists.

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

Section 1. NRS 695G.016 is hereby amended to read as follows:

695G.016 "Clinical peer" means ~~[a]~~ ***:***

1. A physician who is:

~~[1.]~~ ***(a)*** Engaged in the practice of medicine; and

~~[2.]~~ ***(b)*** Certified or is eligible for certification by a member board of the American Board of Medical Specialties in the same or similar area of practice as is the health care service that is the subject of a final adverse determination ~~[.]~~ ***; or***

2. A dentist who is:

(a) Engaged in the practice of dentistry; and

(b) Certified or is eligible for certification by a certifying board approved by the American Dental Association in the same or similar area of practice as is the health care service that is the subject of a final adverse determination.

Sec. 2. NRS 695G.150 is hereby amended to read as follows:

695G.150 Each managed care organization shall authorize coverage of a health care service that has been recommended for the insured by a provider of health care acting within the scope of his or her practice if that service is covered by the health care plan of the insured, unless:

1. The decision not to authorize coverage is made by a physician ***or dentist*** who:

(a) Is licensed to practice medicine ***or dentistry*** in the State of Nevada pursuant to chapter 630 ***, 631*** or 633 of NRS;

(b) Possesses the education, training and expertise to evaluate the medical condition of the insured; and

(c) Has reviewed the available medical documentation, notes of the attending physician ~~[,]~~ ***or dentist,*** test results and other relevant medical records of the insured.

➥ The physician ***or dentist*** may consult with other providers of health care in determining whether to authorize coverage.

2. The decision not to authorize coverage and the reason for the decision have been transmitted in writing in a timely manner to the insured, the provider of health care who recommended the service and the primary care physician ***or dentist*** of the insured, if any.

Sec. 3. NRS 695G.243 is hereby amended to read as follows:

695G.243 1. Except as otherwise provided in subsection 2, the provisions of NRS 695G.200 to 695G.310, inclusive, apply to all health carriers.

2. The provisions of subsection 1 do not apply to:

(a) A policy or certificate that provides only coverage for:

(1) A specified disease or accident;

(2) Accidents;

(3) Credit;

(4) ~~[Dental;~~

~~(5)]~~ Disability income;

~~[(6)]~~ ***(5)*** Hospital indemnity;

~~[(7)]~~ ***(6)*** Long-term care insurance;

~~[(8)]~~ ***(7)*** Vision care; or

~~[(9)]~~ ***(8)*** Any other limited supplemental benefit;

(b) A Medicare supplement policy of insurance, as defined in regulations adopted by the Commissioner;

(c) Coverage under a plan through Medicare, Medicaid or the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. §§ 8901 et seq.;

(d) Any coverage issued under the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 U.S.C. §§ 1071 et seq., and any coverage issued as supplemental to that coverage;

(e) Any coverage issued as supplemental to liability insurance;

(f) Workers' compensation or similar insurance;

(g) Automobile medical payment insurance; or

(h) Any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

Sec. 4. NRS 695G.245 is hereby amended to read as follows:

695G.245 1. A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to NRS 695G.241 to 695G.310, inclusive, and include the appropriate statements and information set forth in subsection 2 at the same time the health carrier sends written notice of an adverse determination upon completion of the health carrier's utilization review process set forth in NRS 683A.375 to 683A.379, inclusive, and the regulations adopted pursuant thereto.

2. As part of the written notice required pursuant to subsection 1, a health carrier shall include the following, or substantially equivalent, language:

> We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Office for Consumer Health Assistance.

3. The Commissioner may prescribe by regulation the form and content of the notice required pursuant to this section.

4. The health carrier shall include in the notice required pursuant to subsection 1 a statement informing the covered person that:

(a) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an adverse determination set forth in NRS 695G.200 to 695G.230, inclusive, would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in NRS 695G.210, file a request for an expedited external review to be conducted pursuant to NRS 695G.271 and 695G.275 if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician ***or dentist, as applicable,*** certifies in writing that the recommended or requested health care service or treatment that is the subject of the

adverse determination would be significantly less effective if not promptly initiated, and the independent review organization assigned to conduct the expedited external review will determine whether the covered person will be required to complete the expedited review of the grievance before conducting the expedited external review; and

(b) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within 30 days after the date on which the covered person or the covered person's authorized representative filed the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to NRS 695G.251 and shall be considered to have exhausted the health carrier's internal grievance process.

5. In addition to the information required to be provided pursuant to subsection 1, the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to NRS 695G.307, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

6. As part of any forms provided pursuant to subsection 3, the health carrier shall include an authorization form, or other document approved by the Commissioner that complies with the requirements of 45 C.F.R. § 164.508, by which the covered person, for purposes of conducting an external review, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

7. As used in this section, "protected health information" has the meaning ascribed to it in 45 C.F.R. § 160.103.

Sec. 5. NRS 695G.251 is hereby amended to read as follows:

695G.251 1. If a covered person or a physician ***or dentist*** of a covered person receives notice of an adverse determination from a health carrier concerning the covered person, the covered person, the physician ***or dentist, as applicable,*** of the covered person or an authorized representative may, within 4 months after receiving notice of the adverse determination, submit a request to the Office

for Consumer Health Assistance for an external review of the adverse determination.

2. Within 5 days after receiving a request pursuant to subsection 1, the Office for Consumer Health Assistance shall notify the covered person, the authorized representative or physician ***or dentist, as applicable,*** of the covered person, the agent who performed utilization review for the health carrier, if any, and the health carrier that the request has been filed with the Office for Consumer Health Assistance.

3. As soon as practicable after receiving a request pursuant to subsection 1, the Office for Consumer Health Assistance shall assign an independent review organization from the list maintained pursuant to NRS 683A.3715. Each assignment made pursuant to this subsection must be completed on a rotating basis.

4. Within 5 days after receiving notification from the Office for Consumer Health Assistance specifying the independent review organization assigned pursuant to subsection 3, the health carrier shall provide to the independent review organization all documents and materials relating to the adverse determination, including, without limitation:

(a) Any medical records of the insured relating to the external review;

(b) A copy of the provisions of the health benefit plan upon which the adverse determination was based;

(c) Any documents used by the health carrier to make the adverse determination;

(d) The reasons for the adverse determination; and

(e) Insofar as practicable, a list that specifies each provider of health care who has provided health care to the covered person and the medical records of the provider of health care relating to the external review.

Sec. 6. NRS 695G.261 is hereby amended to read as follows:

695G.261 1. Except as otherwise provided in NRS 695G.271 and 695G.275, upon receipt of a request for an external review pursuant to NRS 695G.251, the independent review organization shall, within 5 days after receiving the request:

(a) Review the request and the documents and materials submitted pursuant to NRS 695G.251; and

(b) Notify the covered person, the physician ***or dentist, as applicable,*** of the covered person and the health carrier if any additional information is required to conduct a review of the adverse determination. Such additional information must be provided within 5 days after receiving notice that the information is required to conduct a review of the adverse determination. The independent review organization shall forward to the health carrier, within 1

business day after receipt, any information received from a covered person or the physician ***or dentist*** of a covered person.

2. Except as otherwise provided in NRS 695G.271 and 695G.275, the independent review organization shall approve, modify or reverse the adverse determination within 15 days after it receives the information required to make that determination pursuant to this section. The independent review organization shall submit a copy of its determination, including the reasons therefor, to:

(a) The covered person;

(b) The physician ***or dentist, as applicable,*** of the covered person;

(c) The authorized representative of the covered person, if any; and

(d) The health carrier.

Sec. 7. NRS 695G.271 is hereby amended to read as follows:

695G.271 1. The Office for Consumer Health Assistance shall approve or deny a request for an external review of an adverse determination in an expedited manner not later than 72 hours after it receives proof from the provider of health care of the covered person that:

(a) The adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from the facility providing the services or care; or

(b) Failure to proceed in an expedited manner may jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.

2. If the Office for Consumer Health Assistance approves a request for an external review pursuant to subsection 1, the Office for Consumer Health Assistance shall assign the request to an independent review organization not later than 1 working day after approving the request. Each assignment made by the Office for Consumer Health Assistance pursuant to this section must be completed on a rotating basis.

3. Within 24 hours after receiving notice of the Office for Consumer Health Assistance assigning the request, the health carrier shall provide to the independent review organization all documents and materials specified in subsection 4 of NRS 695G.251.

4. An independent review organization that is assigned to conduct an external review pursuant to subsection 2 shall, if it accepts the assignment:

(a) Complete its external review not later than 48 hours after receiving the assignment, unless the covered person and the health carrier agree to a longer period;

(b) Not later than 24 hours after completing its external review, notify the covered person, the physician ***or dentist, as applicable,*** of the covered person, the authorized representative, if any, and the health carrier by telephone of its determination; and

(c) Not later than 48 hours after completing its external review, submit a written decision of its external review to the covered person, the physician ***or dentist, as applicable,*** of the covered person, the authorized representative, if any, and the health carrier.

Sec. 8. NRS 695G.275 is hereby amended to read as follows:

695G.275 1. Within 4 months after receipt of a notice of an adverse determination pursuant to NRS 695G.245 that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the Office for Consumer Health Assistance pursuant to this section.

2. A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination pursuant to NRS 695G.245 that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational if the covered person's treating physician ***or dentist, as applicable,*** certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

3. Upon receipt of a request for an expedited external review pursuant to subsection 2, the Office for Consumer Health Assistance shall immediately notify the health carrier.

4. Immediately upon notice of a request for an expedited external review pursuant to subsection 2, the health carrier shall determine whether the request meets the requirements for review set forth in subsection 12. The health carrier shall immediately notify the Office for Consumer Health Assistance and the covered person and, if applicable, the covered person's authorized representative, of its determination regarding eligibility.

5. The Commissioner may specify the form for the notice of initial determination pursuant to subsection 4 and any supporting information to be included in the notice.

6. The notice of initial determination required by subsection 4 must include a statement that a health carrier's initial determination that a request which is ineligible for external review may be appealed to the Office for Consumer Health Assistance.

7. The Office for Consumer Health Assistance may determine that a request for an expedited external review is eligible for

external review pursuant to subsection 12 and require that it be referred for expedited external review notwithstanding a health carrier's initial determination that the request is ineligible.

8. In making a determination pursuant to subsection 7, the decision of the Office for Consumer Health Assistance must be made in accordance with the terms of the covered person's health benefit plan and is subject to all applicable provisions of the external review process.

9. Upon receipt of the notice that the request for expedited external review meets the requirements for review, the Office for Consumer Health Assistance shall immediately assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to NRS 683A.3715 and notify the health carrier of the name of the assigned independent review organization.

10. Upon receipt of the notice pursuant to subsection 9, the health carrier or utilization review organization shall provide or transmit any documents and information considered in making the adverse determination to the assigned independent review organization electronically or by telephone or facsimile, or any other available expeditious method.

11. Except as otherwise provided in subsection 3, within 1 business day after receipt of a request for external review pursuant to subsection 1, the Office for Consumer Health Assistance shall notify the health carrier.

12. Within 5 business days after receipt of the notice sent pursuant to subsection 11, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(a) The person is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(b) The recommended or requested health care service or treatment that is the subject of the adverse determination:

(1) Would be a covered benefit under the covered person's health benefit plan but for the health carrier's determination that the health care service or treatment is experimental or investigational for a particular medical condition; and

(2) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan;

(c) The covered person's treating physician ***or dentist*** has certified that one of the following situations is applicable:

(1) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(2) Standard health care services or treatments are not medically appropriate for the covered person; or

(3) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in paragraph (d);

(d) The covered person's treating physician ~~[.]~~ ***or dentist:***

(1) Has recommended a health care service or treatment that the physician ***or dentist*** certifies, in writing, is likely to be more beneficial to the covered person, in the ~~[physician's]~~ opinion ~~[,]~~ ***of the physician or dentist,*** than any available standard health care services or treatments; or

(2) Who is a licensed, board certified or board eligible physician ***or dentist*** qualified to practice in the area of medicine ***or dentistry*** appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(e) The covered person has exhausted the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive, unless the covered person is not required to exhaust the health carrier's internal grievance process; and

(f) The covered person has provided all the information and forms required by the Office for Consumer Health Assistance to process an external review, including the release form provided pursuant to subsection 6 of NRS 695G.245.

13. Within 1 business day after completion of the preliminary review, the health carrier shall notify the Office for Consumer Health Assistance and the covered person, and, if applicable, the covered person's authorized representative, in writing, whether the request is:

(a) Complete;

(b) Eligible for external review;

(c) Not complete, in which case the health carrier shall include in the notice the information or materials that are needed to make the request complete; or

(d) Not eligible for external review, in which case the health carrier shall include in the notice the reasons for its ineligibility.

14. The Commissioner may specify the form for the notice of initial determination pursuant to subsection 13 and any supporting information to be included in the notice.

15. The notice of initial determination must include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that a request which is ineligible for external review may be appealed to the Office for Consumer Health Assistance.

16. The Office for Consumer Health Assistance may determine that a request is eligible for external review pursuant to subsection 12 and require that it be referred for external review notwithstanding a health carrier's initial determination that the request is ineligible.

17. In making a determination pursuant to subsection 16, the decision of the Office for Consumer Health Assistance must be made in accordance with the terms of the covered person's health benefit plan and is subject to all applicable provisions of the external review process.

18. When a health carrier determines that a request is eligible for external review pursuant to subsection 12, the health carrier shall notify the Office for Consumer Health Assistance and the covered person and, if applicable, the covered person's authorized representative.

19. Within 1 business day after receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subsection 18, the Office for Consumer Health Assistance shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to NRS 683A.3715 to conduct the external review;

(b) Notify the health carrier of the name of the assigned independent review organization; and

(c) Notify in writing the covered person and, if applicable, the covered person's authorized representative that the request is eligible for external review and provide the name of the assigned independent review organization.

20. The Office for Consumer Health Assistance shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative pursuant to subsection 19 a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within 5 business days after receipt of the notice provided pursuant to subsection 19 additional information that the independent review organization shall consider when conducting the external review. The independent review organization may accept and consider additional information submitted after the 5 business days have elapsed.

21. Within 1 business day after receipt of the notice of assignment to conduct the external review pursuant to subsection 19, the assigned independent review organization shall:

(a) Select one or more clinical reviewers to conduct the external review, as it determines is appropriate; and

(b) Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination.

22. In selecting clinical reviewers pursuant to paragraph (a) of subsection 21, the assigned independent review organization shall select health care professionals who meet the minimum qualifications described in NRS 683A.372 and through clinical experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

23. The covered person, the covered person's authorized representative, if applicable, and the health carrier may not choose or control the choice of the health care professionals to be selected to conduct the external review.

24. In accordance with subsections 37 to 41, inclusive, each clinical reviewer shall provide a written opinion to the assigned independent review organization regarding whether the recommended or requested health care service or treatment should be covered.

25. In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in NRS 683A.375 to 683A.379, inclusive, or the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive.

26. Within 5 business days after receipt of the notice pursuant to subsection 19, the health carrier or utilization review organization shall provide to the assigned independent review organization any documents and information considered in making the adverse determination.

27. Except as otherwise provided in subsection 28, failure by the health carrier or utilization review organization to provide the documents and information within the time specified in subsection 26 must not delay the conduct of the external review.

28. If the health carrier or utilization review organization fails to provide the documents and information within the time specified in subsection 26, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination.

29. If the independent review organization elects to terminate the external review and reverse the adverse determination pursuant to subsection 28, the independent review organization shall immediately notify the covered person, the covered person's authorized representative, if applicable, the health carrier and the Office for Consumer Health Assistance.

30. Each clinical reviewer selected pursuant to subsection 21 shall review all the information and documents received pursuant to subsections 20 and 26.

31. The assigned independent review organization shall forward any information submitted by the covered person or the covered person's authorized representative pursuant to subsection 20 to the health carrier within 1 business day after receipt of the information.

32. Upon receipt of the information required to be forwarded pursuant to subsection 31, the health carrier may reconsider the adverse determination that is the subject of the external review.

33. Reconsideration by the health carrier of its adverse determination pursuant to subsection 32 must not delay or terminate the external review.

34. Except as otherwise provided in subsection 28, the external review may only be terminated before completion if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination.

35. If the health carrier reverses its adverse determination pursuant to subsection 28, the health carrier shall immediately notify the covered person, the covered person's authorized representative, if applicable, the assigned independent review organization and the Office for Consumer Health Assistance in writing of its decision.

36. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier pursuant to subsection 35.

37. Except as otherwise provided in subsection 39, within 20 days after being selected in accordance with subsection 21 to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection 41 regarding whether the recommended or requested health care service or treatment should be covered.

38. Except for an opinion provided pursuant to subsection 39, each clinical reviewer's opinion must be in writing and include the following:

(a) A description of the covered person's medical condition;

(b) A description of the indicators relevant to determine if there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(c) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(d) A description and analysis of any evidence-based standards used as a basis for the opinion; and

(e) Information concerning whether the reviewer's rationale for the opinion is based on the provisions of subsection 41.

39. For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event not more than 5 calendar days after being selected in accordance with subsection 21.

40. If the opinion provided pursuant to subsection 39 was not in writing, within 48 hours after providing that notice, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required pursuant to subsection 38.

41. In addition to the documents and information provided pursuant to subsections 10 and 26, each clinical reviewer, to the extent the information or documents are available and the reviewer considers them appropriate, shall consider the following in reaching an opinion:

(a) The covered person's medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

(d) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the health benefit plan; and

(e) Whether:

(1) The recommended or requested health care service or treatment has been approved by the Food and Drug Administration, if applicable, for the condition; or

(2) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

42. Except as otherwise provided in subsection 43, within 20 days after receipt of the opinion of each clinical reviewer pursuant to subsection 41, the assigned independent review organization, in accordance with subsection 45 or 46, shall make a decision and provide written notice of the decision to the covered person, the covered person's authorized representative, if applicable, the health carrier and the Office for Consumer Health Assistance and include the information required pursuant to subsection 50.

43. For an expedited external review, within 48 hours after receipt of the opinion of each clinical reviewer pursuant to subsection 41, the assigned independent review organization, in accordance with subsection 45 or 46, shall make a decision and provide notice of the decision orally or in writing to the covered person, the covered person's authorized representative, if applicable, the health carrier and the Office for Consumer Health Assistance.

44. If the notice provided pursuant to subsection 43 was not in writing, within 48 hours after providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the covered person, the covered person's authorized representative, if applicable, the health carrier and the Office for Consumer Health Assistance and include the information required pursuant to subsection 50.

45. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination.

46. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination.

47. If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the

independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subsection 45 or 46.

48. The additional clinical reviewer selected pursuant to subsection 47 shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection 41.

49. The selection of an additional clinical reviewer pursuant to subsection 47 must not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers pursuant to subsection 42.

50. The independent review organization shall include in the notice provided pursuant to subsection 42 or 44:

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(c) The date the independent review organization was assigned by the Office for Consumer Health Assistance to conduct the external review;

(d) The date on which the external review was conducted;

(e) The date of the decision;

(f) The principal reason or reasons for the decision; and

(g) The rationale for the decision.

51. Upon receipt of a notice of a decision pursuant to subsection 42 or 44 reversing the adverse determination, the health carrier shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination.

52. The assignment by the Office for Consumer Health Assistance of an approved independent review organization to conduct an external review in accordance with this section must be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination and other circumstances, including concerns regarding conflicts of interest pursuant to subsection 4 of NRS 683A.372.

53. As used in this section:

(a) "Best evidence" means evidence based on:

(1) Randomized clinical trials;

(2) If randomized clinical trials are not available, cohort studies or case-control studies;

(3) If the methods described in subparagraphs (1) and (2) are not available, case series; or

(4) If the methods described in subparagraphs (1), (2) and (3) are not available, expert opinion.

(b) "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of research in making decisions about the care of an individual patient.

(c) "Randomized clinical trial" means a controlled, prospective study of patients who have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

Sec. 9. NRS 695G.280 is hereby amended to read as follows:

695G.280 The decision of an independent review organization concerning a request for an external review must be based on:

1. Documentary evidence, including any recommendation of the physician ***or dentist*** of the insured submitted pursuant to NRS 695G.251;

2. Medical or scientific evidence, including, without limitation:

(a) Professional standards of safety and effectiveness for diagnosis, care and treatment that are generally recognized in the United States;

(b) Any report published in literature that is peer-reviewed;

(c) Evidence-based medicine, including, without limitation, reports and guidelines that are published by professional organizations that are recognized nationally and that include supporting scientific data; and

(d) An opinion of an independent physician ***or dentist*** who, as determined by the independent review organization, is an expert in the health specialty that is the subject of the independent review; and

3. The terms and conditions for benefits set forth in the evidence of coverage issued to the insured by the health carrier.