## POLICY

It is the policy of the Office for Consumer Health Assistance of Health and Human Services (DHHS), pursuant to NRS 439B, to develop permanent regulations for:

1. Arbitration for claims of less than $5,000 for medically necessary emergency services for out-of-network emergency facilities, out-of-network providers and third parties.
2. Election of a third party that is not otherwise subject to the provisions of NRS 439B.700 to 439B.760 to make such an election.
3. Information requested by DHHS relevant to the report outlined in NRS 439B.760.

## PURPOSE

To clarify procedures for establishing a process for arbitration for claims of less than $5,000 for medically necessary emergency services for out-of-network emergency facilities, out-of-network providers and third parties, election of a third party that is not otherwise subject to the provisions of NRS 439B.700 to 439B.760 to make such an election and information requested by DHHS relevant to the report outlined in NRS 439B.760.

## DEFINITIONS

**"Covered person"** - A policyholder, subscriber, enrollee or other person covered by a third party.

**"Independent center for emergency medical care"** – As ascribed in NRS 449.013.

**"In-network emergency facility"** - A hospital or independent center for emergency medical care that is an in-network provider.

**"In-network provider"** - For a particular covered person, a provider of health care that has entered into a provider contract with a third party for the provision of health care to the covered person.

**"Medically necessary emergency services"** - Health care services that are provided by a provider of health care to screen and to stabilize a covered person after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

1. Serious jeopardy to the health of the covered person;
2. Serious jeopardy to the health of an unborn child of the covered person;
3. Serious impairment of a bodily function of the covered person; or
4. Serious dysfunction of any bodily organ or part of the covered person.

**"Out-of-network emergency facility"** – A hospital or independent center for emergency medical care that is an out-of-network provider.

**"Out-of-network provider"** - For a particular covered person, a provider of health care that has not entered into a provider contract with a third party for the provision of health care to the covered person.

**"Provider contract"** - A contract between a third party and an in-network provider to provide health care services to a covered person.

**"Provider of health care"** - As ascribed in NRS 695G.070.

**"Prudent person"** - A person who:

1. Is not a provider of health care;
2. Possesses an average knowledge of health and medicine; and
3. Is acting reasonably under the circumstances.

**"Screen"** - To conduct the medical screening examination required to be provided to a patient in the emergency Office for Consumer Health Assistance of a hospital pursuant to 42 U.S.C. § 1395dd.

**"Third party"**

1. Includes, without limitation:
    a. The issuer of a health benefit plan, as defined in NRS 695G.019, which provides coverage for medically necessary emergency services;
    b. The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043; and
    c. Any other entity or organization that elects to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons pursuant to AB469.
2. Does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Office for Consumer Health Assistance.

**"To stabilize"** and **"stabilized"** – as ascribed in 42 U.S.C. § 1395dd(e)(3).

## REFERENCES

1. NEVADA REVISED STATUTE (NRS) 439B – "RESTRAINING COSTS OF HEALTHCARE"

## PROCEDURE

### A. PROCESS TO REQUEST A LIST OF RANDOMLY SELECTED ARBITRATORS, PURSUANT TO SUBSECTION 3 OF NRS 439B.754, TO ARBITRATE A DISPUTE OVER A CLAIM OF LESS THAN $5,000

1. An out-of-network provider must submit a request to the Office for Consumer Health Assistance. If the out-of-network provider submits the request because the third party has refused or failed to pay the additional amount requested by the out-of-network-provider pursuant to subsection 2 of NRS 439B.754, the out-of-network provider must submit the request by:

    d. If the third party refused to pay the additional amount, not later than 30 business days after the date on which the third party notifies the out-of-network provider of the refusal.

    e. If the third party failed to pay the additional amount for 30 business days after receiving a request for the additional amount, not later than 30 business days after that date.

5. A request submitted pursuant to subsection 1 must be in the form prescribed by the Office for Consumer Health Assistance and include, without limitation:

    a. The date on which the medically necessary emergency services to which the complaint pertains were provided and the type of medically necessary emergency services provided;

    b. The contact information for and location of the out-of-network provider that provided the medically necessary emergency services;

    c. The type and specialty of each health care practitioner who provided the medically necessary emergency services;

    d. The type of third party that provides coverage for the covered person to whom the medically necessary emergency medical services were rendered and contact information for that third party; and

    e. Documentation of:

        1) The date on which the out-of-network provider received payment from the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, and the amount of payment received;

        2) The date on which the out-of-network provider requested additional payment from the third party pursuant to subsection 2 of NRS 439B.754, and the additional amount requested; and

        3) The date the third party refused to pay the additional amount or failed to pay the additional amount.

6. If the Office for Consumer Health Assistance does not receive a request pursuant to subsection 1 within the prescribed time, the out-of-network provider shall be deemed to have accepted the payment received from the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, as payment in full for the medically necessary emergency services.
    a. Not later than 10 business days after receiving a request pursuant to subsection 1, the Office for Consumer Health Assistance shall notify the out-of-network provider in writing of the receipt of the request. Not later than 20 business days after days after the written notification of the receipt of the request, the Office for Consumer Health Assistance review the request and verify the information contained therein; and
    b. Notify the out-of-network provider in writing of any additional information necessary to complete or clarify the request.
7. The Office for Consumer Health Assistance will approve a request not later than 5 business days after determining that the request is complete and clear. A complete and clear request includes the documentation pursuant to subsection 2 of section 2 of this regulation. Not later than 5 business days after approving a request, the Office for Consumer Health Assistance shall:
    a. Notify the out-of-network provider and the third party in writing of the approval; and
    b. Provide the out-of-network provider and third party with a written list of five randomly selected employees of the Office for Consumer Health Assistance of the Office for Consumer Health Assistance who are qualified to arbitrate the dispute.

B. **ARBITRATON SELECTION AND PROCESS FOR CLAIMS UNDER $5,000**

1. Not later than 10 business days from the date the written list of arbitrators is provided by the Office for Consumer Health Assistance, the out-of-network provider and third party shall strike up to 2 arbitrators from the list in the manner required by subsection 4 of NRS 439B.754 party must select an arbitrator based on NRS 439B.754 (4) and provide the names of the remaining arbitrators on the list in writing to the Office for Consumer Health Assistance (an arbitration selection form will be provided by the Office for Consumer Health Assistance).
2. Not later than 10 business days after receiving the names of the remaining arbitrators from both the out-of-network provider and third party, the Office for Consumer Health Assistance shall:
    a. If one arbitrator remains, notify the out-of-network provider and the third party in writing of the name of that arbitrator.
    b. If more than one arbitrator remains, randomly select an arbitrator from the remaining arbitrators as required by subsection 4 of NRS 439B.754 and notify

the out-of-network provider and the third party in writing of the name of that arbitrator.

c. Pursuant to NRS 232.461, ensure the selected arbitrator does not have a conflict of interest that would adversely impact the arbitrator's impartiality in rendering a decision.

d. The out-of-network provider or third party may provide the arbitrator with any relevant information to assist the arbitrator in making a determination, not later than 10 business days from the date the Office for Consumer Health Assistance notifies the out-of-network provider and the third party in writing of the name of the arbitrator.

3. An arbitrator selected pursuant to section B subsection 2 may request from the third party and the out-of-network provider any information the arbitrator deems necessary to assist in making a determination. The out-of-network provider and third party shall provide such information to the arbitrator not later than 10 business days from the date of the request. If either party fails to provide information requested by the arbitrator within that time, the arbitrator may proceed and make a determination based on the evidence available to the arbitrator.

4. Not later than 45 business days after the expiration of the period for submission of the information pursuant to subsection 2 (d) or subsection 3 of policy section B, as applicable, the arbitrator shall make a determination as provided in subsection 6 of NRS 439B.754 and notify the parties of that determination.

C. **PROCESS TO REQUEST A LIST OF RANDOMLY SELECTED ARBITRATORS, PURSUANT TO SUBSECTION 3 OF NRS 439B.754, TO ARBITRATE A DISPUTE OVER A CLAIM OF 5,000, OR MORE**

1. An out-of-network provider must request a list of five randomly selected arbitrators from:

    a. The American Arbitration Association or its successor organization; or

    b. JAMS or its successor organization.

D. **PROCESS TO ELECT TO HAVE THE PROVISIONS OF NRS 439B.700 TO 439B.760, INCLUSIVE, APPLY TO AN ENTITY OR ORGANIZATION THAT IS NOT OTHERWISE SUBJECT TO THOSE PROVISIONS AS AUTHORIZED PURSUANT TO NRS 439B.757 AND PROCESS TO WITHDRAW FROM ELECTION.**

1. The entity or organization must apply to the Department in the form prescribed by the Department. The application must include, without limitation:

    a. The name of and contact information of the entity or organization; and

    b. A description of the type of entity or organization, as applicable, that it is.

2. Applications received between the 1st and the 14th of the month will be effective the 1st of the following month. Applications received between the 15th through the end of the month

will be effective the 15th of the following month. Dates of service that fall on or after the third party participation effective date are eligible for arbitration.

3. Any entity or organization may withdraw its election to have the provisions of NRS 439B.700 to 439B.760, inclusive, apply to the entity or organization by submitting an application to the Department in the form prescribed by the Department not less than 120 business days before the date on which the withdrawal is requested to become effective. The application must include, without limitation:
    a. The name of and contact information for the entity or organization;
    b. A description of the type of entity or organization, as applicable, that it is;
    c. The date on which the entity or organization requests the withdrawal to become effective; and
    d. The reason for requesting to withdraw the election.

E. **NRS 436B.760 PROVIDER AND THIRD PARTY REPORTING**

1. On or before December 31 of each year, each provider of medically necessary emergency services in this State shall submit to the Department in the form prescribed by the Department:
    a. The name of and contact information for the provider;
    b. A description of the type of provider that it is;
    c. Whether there was an increase in the number of new third party contracts entered into by the provider of medically necessary emergency services and the percentage of the increase from the immediately preceding year and the types of third parties with whom third party contracts were entered into; and
    d. Whether there was a decrease in the number of third party contracts between the provider of medically necessary emergency services and the third party and the percentage of the decrease from the immediately preceding year.
2. On or before December 31 of each year, each third party that provides coverage to residents of this State shall submit to the Department in the form prescribed by the Department:
    a. The name of and contact information for the third party;
    b. A description of the type of third party that it is;
    c. Whether there was an increase in the number of new provider contracts entered into by the third party with providers of medically necessary emergency services and the percentage of the increase from the immediately preceding year and the types of providers with whom provider contracts were entered into; and

d. Whether there was a decrease in the number of provider contracts between the third party and providers of medically necessary emergency services and the percentage of the decrease from the immediately preceding year.