



**Department of Health and Human Services
Office for Consumer Health Assistance
Payment for Medically Necessary Emergency
Services Provided Out-of-Network
2020 Annual Report**

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Introduction

In the Nevada 2019 Legislature, Assembly Bill No. 469 sponsored by the Committee on Health and Human Services was passed. Assembly Bill No. 469 (AB469) is an act which limits the amount a provider of health care may charge a person who has health insurance for certain medically necessary emergency services provided when the provider is out-of-network. This act removes the consumer from being balance billed under certain circumstances. The Nevada Department of Health and Human Services, Office for Consumer Health Assistance (OCHA) was designated to conduct arbitrations by qualified employees for claims of less than \$5,000.

In November 2019 OCHA submitted to the Legislative Counsel Bureau (LCB) proposed, draft permanent regulation for AB469. LCB returned the review of the proposed regulation, LCB File No. R101-19, in January 2020. Based on results of a small business impact study, public workshops, recommendations, and meetings with stakeholders OCHA revised proposed regulation LCB File No. R101-19. The revised proposed regulation was submitted to LCB in May 2020 for review. September 2020 OCHA received an email from LCB that the revised regulations have been drafted and are now in the review process. Another public workshop will be scheduled after OCHA receives the revised draft regulations from LCB.

Along with development of draft regulations, OCHA hired two new positions received in the 2019 legislature, Consumer Health Advocacy Specialist (Chief) and Management Analyst 2. Additionally, OCHA began work with a contract vendor to capture basic startup requirements for the arbitration process and to meet the mandated reporting requirements of AB469 with a long-term goal of developing a relational SQL database. This includes building the framework to screen in/out requests for arbitration applications, arbitration documentation and produce required reports. Presently, this contractor is working with State IT developers to create a SQL database which will give OCHA the capability to fully implement the necessary workflow, documentation of arbitration requests, cases, and report arbitration data elements. The SQL database will be accessible for staff statewide.

Draft regulations, policy, procedures, and forms were developed specific to the arbitration process allowing OCHA staff to process request for arbitration applications and conduct arbitrations. With stakeholder feedback in consideration, instructions for completing the Request for Arbitration Application was completed and posted to OCHA's website. In March 2020 OCHA began receiving arbitrations requests for claims under \$5,000 for medically necessary emergency services as outlined in NRS 439B.754.

The following report provides data and analysis regarding arbitrations for calendar year 2020. Additional reference material is provided at the end of the report: [List of Exhibits](#)

Arbitrations of Claims Less Than \$5,000

Intake Process

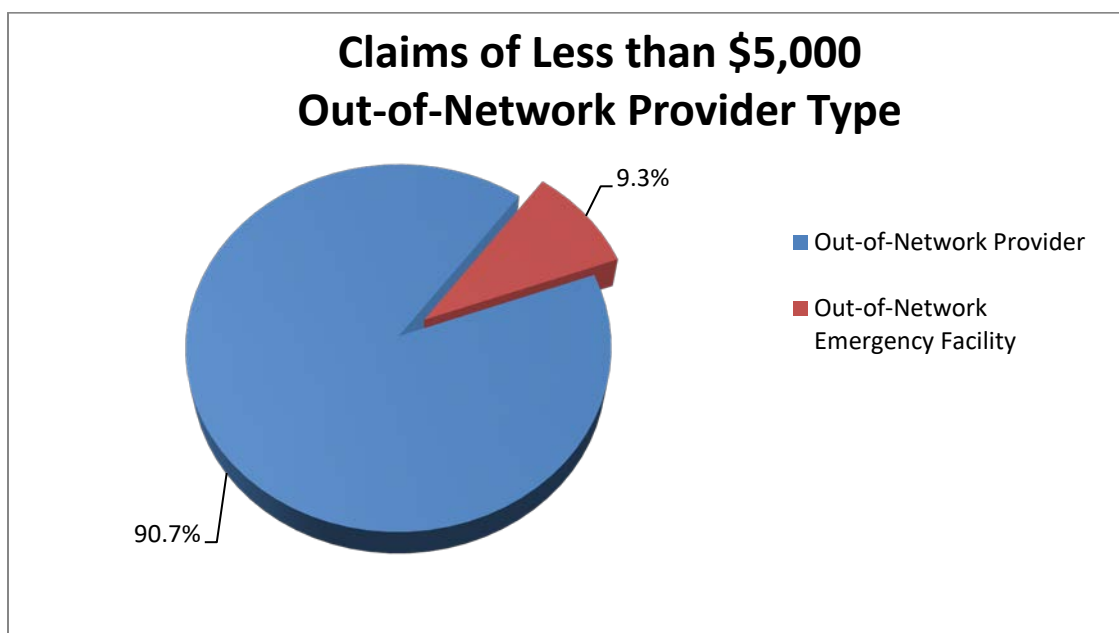
Request for Arbitration applications can be downloaded by the Out-of-Network Provider or Out-of-Network Emergency Facility from the OCHA website at <http://dhhs.nv.gov/Programs/CHA/>. Request for Arbitration applications are submitted to OCHA via email, fax, or regular mail.

The first application was received on March 11, 2020. As of December 31, 2020, OCHA received 782 Request for Arbitration applications.

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Office for Consumer Health Assistance applications received by county For applications received between 01/01/2020 and 12/31/2020

County	Jan - March		April - June		July - September		October - December		Total
	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	
Carson City	26	0	40	0	35	0	16	0	117
Clark	47	0	52	16	17	8	0	3	143
Douglas	0	0	5	0	5	0	5	0	15
Washoe	83	0	217	11	128	24	33	11	507
Statewide Total	156	0	314	27	185	32	54	14	782



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The charts above references total applications received from Out-of-Network Providers and Out-of-Network Emergency Facilities.

Analysis of the data above shows Out-of-Network Providers submitted the majority of applications throughout the year, while Out-of-Network Emergency Facilities began submitting applications in May 2020. The highest number of Request for Arbitration applications were received from providers in Washoe County while the lowest number received was from providers in Douglas County.

The chart below has information about applications received by types of providers of health care.

STATE OF NEVADA

Office for Consumer Health Assistance applications by types of providers of health care
 For applications received between 01/01/2020 and 12/31/2020

County	Jan - March		April - June		July - September		October - December		Total
	Emergency Medicine	Emergency Facility	Emergency Medicine	Emergency Facility	Emergency Medicine	Emergency Facility	Emergency Medicine	Emergency Facility	
Carson City	26	0	40	0	35	0	16	0	117
Clark	47	0	52	16	17	8	0	3	143
Douglas	0	0	5	0	5	0	5	0	15
Washoe	83	0	217	11	128	24	33	11	507
Statewide Total	156	0	314	27	185	32	54	14	782

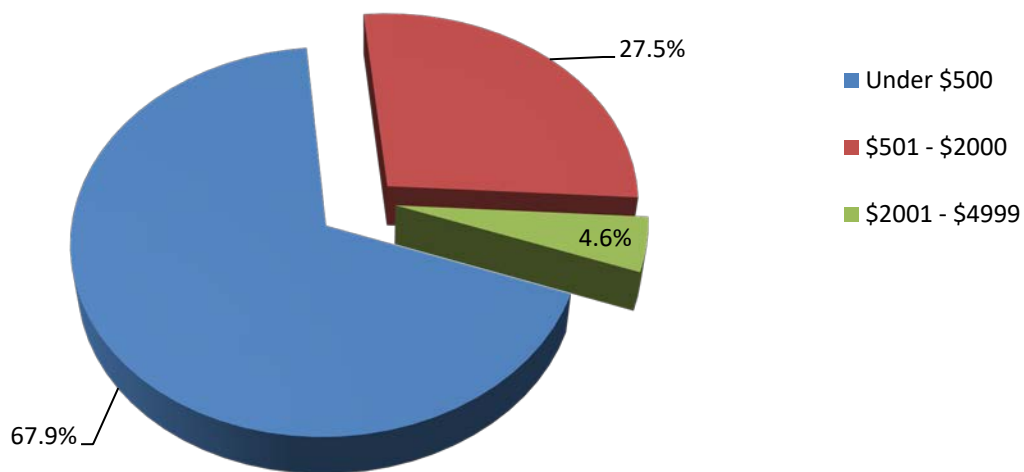
The charts below displays information about additional amounts requested by Out-of-Network Providers and Out-of-Network Emergency Facilities for the 782 applications received.

STATE OF NEVADA

Office for Consumer Health Assistance Additional Amount Requested by Out-of-Network Providers and Out-of-Network Emergency Facilities for Applications Received by County
 For applications received between 01/01/2020 and 12/31/2020

County	Under \$500					\$501 to \$2000			\$2001 - \$4999			Total
	\$0 to \$100	\$101 to \$200	\$201 to \$300	\$301 to \$400	\$401 to \$500	\$501 to \$1000	1001 to \$1500	\$1501 to \$2000	\$2001 to \$3000	\$3001 to \$4000	\$4001 to \$4999	
Carson City	6	44	30	21	12	3	1	0	0	0	0	117
Clark	3	1	19	6	19	72	6	4	3	6	4	143
Douglas	0	9	6	0	0	0	0	0	0	0	0	15
Washoe	16	119	62	104	54	106	17	6	14	4	5	507
Statewide Total	25	173	117	131	85	181	24	10	17	10	9	782

Claims of Less than \$5,000 Additional Amount Requested by Out-of-Network Providers and Out-of-Network Facilities



Analysis of the data shows the majority of additional amounts requested (67.9%) were less than or equal to \$500.

Screening Process

The screening process includes OCHA thoroughly reviewing each application to ensure the application is accurate, complete, and meets timeframes required in statute.

If the application has missing or inaccurate data, this is considered an incomplete application. The provider is notified of the missing or inaccurate data and may re-submit the application within 10 business days.

The chart below references the applications received and shows the reasons applications did not meet criteria (ineligible) for arbitration.

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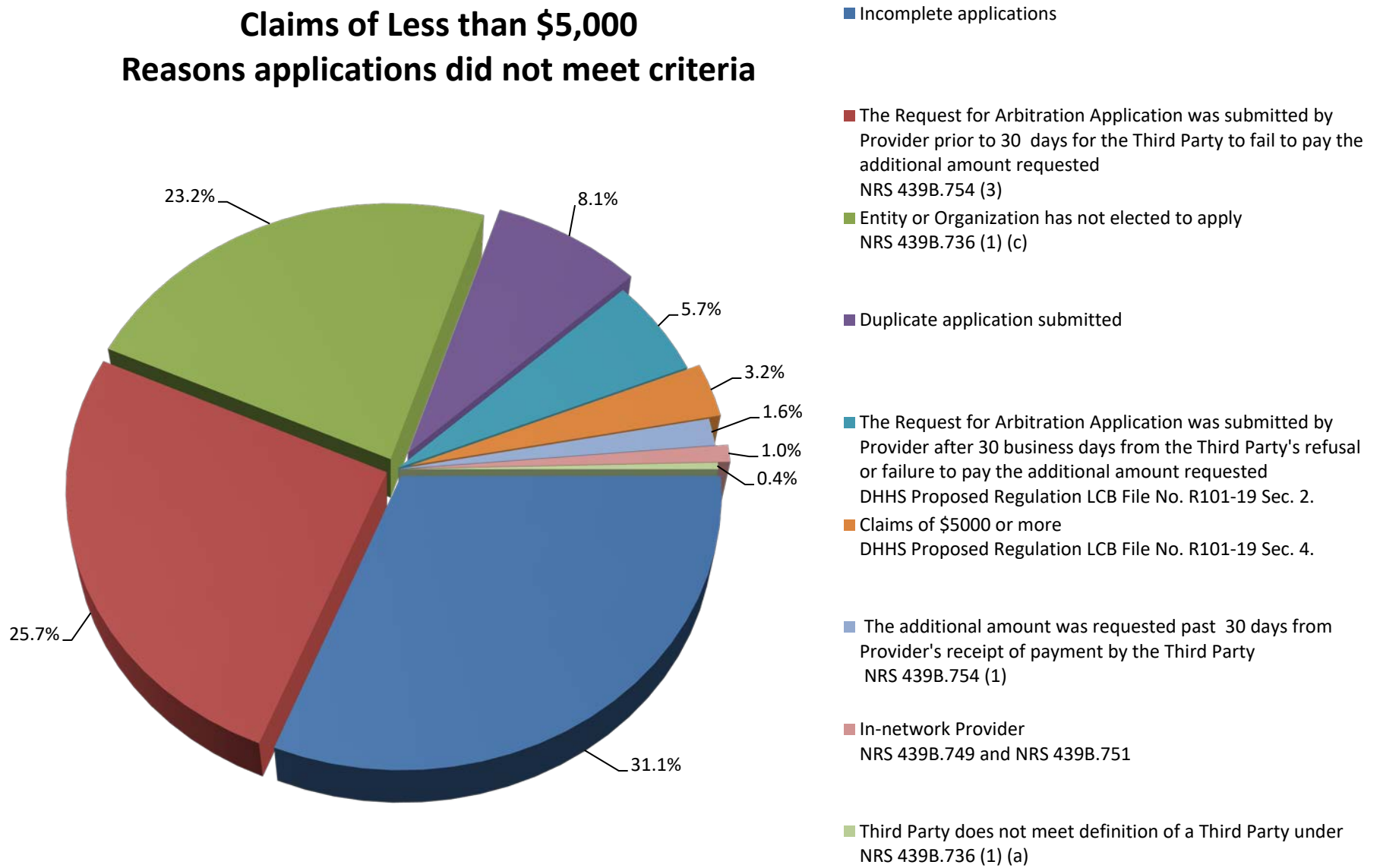
Office for Consumer Health Assistance applications that did not meet criteria for arbitration For applications received between 01/01/2020 and 12/31/2020

Reasons applications did not meet criteria	Jan - March		April - June		July - September		October - December		Total	Percent
	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility		
Incomplete applications	29	0	105	8	9	3	3	0	157	31.1%
The Request for Arbitration Application was submitted by Provider prior to 30 days for the Third Party to fail to pay the additional amount requested NRS 439B.754 (3)	0	0	0	0	103	10	13	4	130	25.7%
Entity or Organization has not elected to apply NRS 439B.736 (1) (c)	89	0	28	0	0	0	0	0	117	23.2%
Duplicate application submitted	8	0	16	1	11	0	5	0	41	8.1%

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The Request for Arbitration Application was submitted by Provider after 30 business days from the Third Party's refusal or failure to pay the additional amount requested DHHS Proposed Regulation LCB File No. R101-19 Sec. 2.	0	0	15	0	3	11	0	0	29	5.7%
Claims of \$5000 or more DHHS Proposed Regulation LCB File No. R101-19 Sec. 4.	0	0	0	10	2	3	0	1	16	3.2%
The additional amount was requested past 30 days from Provider's receipt of payment by the Third Party NRS 439B.754 (1)	0	0	3	0	4	0	0	1	8	1.6%
In-network Provider NRS 439B.749 and NRS 439B.751	0	0	5	0	0	0	0	0	5	1.0%
Third Party does not meet definition of a Third Party under NRS 439B.736 (1) (a)	0	0	0	0	2	0	0	0	2	0.4%
Statewide Total	126	0	172	19	134	27	21	6	505	100.0%

Claims of Less than \$5,000 Reasons applications did not meet criteria



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Analysis of the data above shows there are three main reasons an application did not meet criteria for arbitration:

1. 31.1%, Application Incomplete:
OCHA identified in the early months of receiving applications that a high number of applications contained missing or inaccurate data. OCHA collaborated with stakeholders to review application requirements and refine the application submission process. This resulted in an improvement in receiving complete applications.

2. 25.7%, The Request for Arbitration Application was submitted by Provider prior to 30 days for the Third Party to fail to pay the additional amount requested, NRS 439B.754 (3):
OCHA identified in July that a high number of applications were submitted prior to the allowing the Third Party 30 days to fail to respond to the Provider’s request for additional payment. OCHA provided education to stakeholders regarding time frames for submitting applications. This resulted in an improvement in receiving timely applications.

3. 23.2%, Entity or Organization has not elected to the provisions of NRS 439B.700 to 439B.760, NRS 439B.736 (1) (c):
OCHA recognized many of the first applications submitted were for other Entities or Organizations (i.e. Third Parties) which had not elected to participate in the provisions of NRS 439B.700 to 439B.760 (arbitrations). OCHA updated the Request for Arbitration application to clarify which Third Parties are eligible to participate in arbitrations. This resulted in an improvement in reporting of Third Parties.

In summary, the screening decision statuses as of December 31, 2020, are seen in the chart below.

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Office for Consumer Health Assistance Applications Received by Screening Decision Status

For applications received between 01/01/2020 and 12/31/2020

Screening Decision Status	Jan - March		April - June		July - September		October - December		Total	Percent
	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility		
Criteria met	30	0	142	8	51	5	21	5	262	33.5%
Criteria not met	126	0	172	19	134	27	21	6	505	64.6%
Under review	0	0	0	0	0	0	12	3	15	1.9%
Statewide Total	156	0	314	27	185	32	54	14	782	100.0%

Arbitration Process

The arbitration process includes all of the applications reviewed which initially met criteria to open an arbitration case. Once an arbitration case has been opened a Notice of Arbitration letter is sent to the Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party.

The chart below summarizes the number of applications received which met criteria for arbitration in the screening process.

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Office for Consumer Health Assistance Applications Received by Screening Decision Status

For applications received between 01/01/2020 and 12/31/2020

Screening Decision Status	Jan - March		April - June		July - September		October - December		Total
	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	
Criteria met	30	0	142	8	51	5	21	5	262

Initially, 262 arbitration cases were opened based on the screening process. At the end of the reporting period there were cases which did not meet criteria (111), cases still in progress (54), and cases which were closed with a determination for a prevailing party (97).

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Office for Consumer Health Assistance arbitration cases by Status

For arbitrations between 01/01/2020 and 12/31/2020

Arbitration Cases by Status	Jan - March		April - June		July - September		October - December		Total	Percent
	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility		
Cases closed due to inapplicability	0	0	23	0	53	1	34	0	111	42.4%
Cases in arbitration	0	0	0	0	15	1	29	9	54	20.6%
Cases closed with a Prevailing Party	0	0	3	0	17	0	70	7	97	37.0%
Statewide Total	0	0	3	0	32	1	99	16	262	100.0%

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When the Notice of Arbitration letter is received by the Third Party, the Third Party verifies the claim, health plan and provider information.

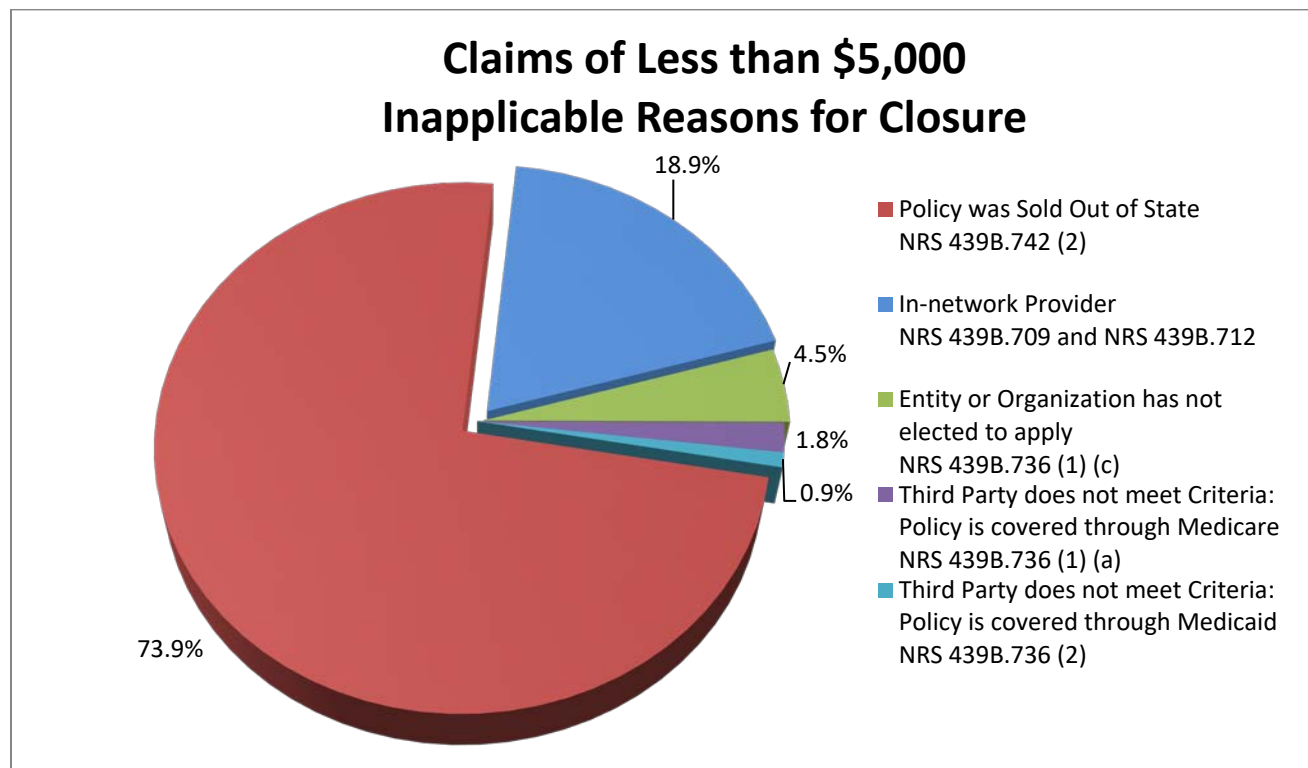
Upon verification of the claim, health plan and provider information the Third Party may find information which did not meet criteria. The Third Party provides documentation to OCHA specific to this information. OCHA reviews the documentation and makes a determination if the arbitration case did not meet criteria for arbitration. The arbitration cases which do not meet criteria are inapplicable as defined in statute.

The chart below references the arbitration cases OCHA reviewed and made a determination the arbitration case was inapplicable.

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**Office for Consumer Health Assistance arbitration cases closed due to Inapplicable Reasons
 For arbitrations closed between 01/01/2020 and 12/31/2020**

Inapplicable Reasons for Closure	Jan - March		April - June		July - September		October - December		Total	Percent
	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility	Out-of-Network Provider	Out-of-Network Emergency Facility		
Policy was Sold Out of State NRS 439B.742 (2)	0	0	19	0	42	1	20	0	82	73.9%
In-network Provider NRS 439B.709 and NRS 439B.712	0	0	1	0	8	0	12	0	21	18.9%
Entity or Organization has not elected to apply NRS 439B.736 (1) (c)	0	0	2	0	1	0	2	0	5	4.5%
Third Party does not meet Criteria: Policy is covered through Medicare NRS 439B.736 (1) (a)	0	0	0	0	2	0	0	0	2	1.8%
Third Party does not meet Criteria: Policy is covered through Medicaid NRS 439B.736 (2)	0	0	1	0	0	0	0	0	1	0.9%
Statewide Total	0	0	23	0	53	1	34	0	111	100.0%



Analysis of the data above shows there are two main reasons an arbitration case did not meet criteria for arbitration:

1. 73.9%, Policy was Sold Out of State, NRS 439B.742 (2):
Upon review of relevant information OCHA verified the policies for these arbitration cases were sold out of state.
2. 18.9% In-network Provider, NRS 439B.709 and NRS 439B.712:
Upon review of relevant information OCHA verified the providers for these arbitration cases were in-network providers.

At the close of the reporting period there were 54 arbitration cases in the review process with an assigned arbitrator. Upon assignment the assigned arbitrator shall make a determination within 45 business days. For these 54 arbitration cases in the review process each step will be completed.

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The timeline below shows the minimum number of business days (106) needed to complete the Arbitration Determination process from receipt of application, through the screening process and to the final determination.

Analysis of the average time needed to complete the Arbitration Determination process in this reporting period was 118 business days (approximately 4 months). Incomplete applications have an impact on the average time to complete the Arbitration Determination process.

Timeline	Number of business days
1. OCHA receives an application from an Out-of-Network Provider or Out-of-Network Emergency Facility	1
2. OCHA acknowledges receipt of Out-of-Network Provider or Out-of-Network Emergency Facility application	10
3. OCHA completes review of application. OCHA sends a Notification of Arbitration to the Out-of-Network Provider or Out-of-Network Emergency Facility and Third Party	20
4. The Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party submits Arbitrator selections to OCHA	10
5. OCHA sends a notification of assigned Arbitrator and request for relevant information from the Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party	10
6. Relevant Information is due from the Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party	10
7. OCHA's assigned Arbitrator reviews all relevant information provided. OCHA's assigned Arbitrator renders a determination. OCHA sends a Notice of Arbitration Determination to Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party	45
Total business days	106

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Arbitration Case Data

As of December 31, 2020, there were 97 arbitration cases closed with a determination and a prevailing party. These 97 arbitration cases went through each step of the process identified in the timeline above.

The chart below displays information about arbitration cases by types of providers of health care as reported on the Request for Arbitration Applications.

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Office for Consumer Health Assistance arbitration cases by types of providers of health care

For arbitrations closed between 01/01/2020 and 12/31/2020

County	Jan - March		April - June		July - September		October - December		Total
	Emergency Medicine	Emergency Facility	Emergency Medicine	Emergency Facility	Emergency Medicine	Emergency Facility	Emergency Medicine	Emergency Facility	
Carson City	0	0	2	0	4	0	39	0	45
Clark	0	0	0	0	4	0	10	2	16
Douglas	0	0	0	0	0	0	0	0	0
Washoe	0	0	1	0	9	0	21	5	36
Statewide Total	0	0	3	0	17	0	70	7	97

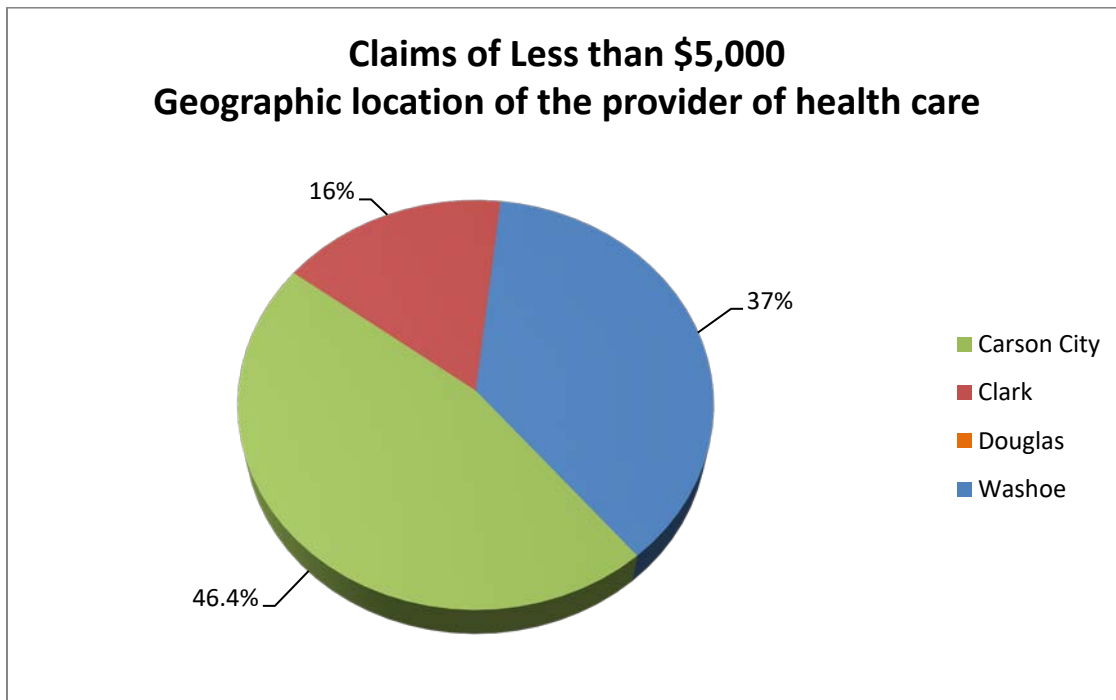
The charts below display information about the geographic location of the provider of health care for medically necessary emergency services in arbitration cases.

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Office for Consumer Health Assistance arbitration cases by geographic location of the provider of health care for medically necessary emergency services

For arbitrations closed between 01/01/2020 and 12/31/2020

County	Out-of-Network Provider	Out-of-Network Emergency Facility	Total
Carson City	45	0	45
Clark	14	2	16
Douglas	0	0	0
Washoe	31	5	36
Statewide Total	90	7	97



The chart below references the arbitrations closed with a prevailing party.

STATE OF NEVADA

Office for Consumer Health Assistance arbitration cases by County and Prevailing Party

For arbitrations closed between 01/01/2020 and 12/31/2020

County	Prevailing Party - Provider		Prevailing Party - Third Party			Total
	Out-of-Network Provider	Out-of-Network Emergency Facility	Issuer of a Health Benefit plan as defined by NRS 695G.019	Public Employees' Benefits Program (PEBP)	Elect-in Entity or Organization	
Carson City	2	0	43	0	0	45
Clark	0	0	16	0	0	16
Douglas	0	0	0	0	0	0
Washoe	5	4	27	0	0	36
Statewide Total	7	4	86	0	0	97

The chart below represents the additional amount requested by prevailing party.

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Office for Consumer Health Assistance arbitration cases by County and Prevailing Party

For arbitrations closed between 01/01/2020 and 12/31/2020

County	Prevailing Party - Provider		Prevailing Party - Third Party			Total
	Out-of-Network Provider	Out-of-Network Emergency Facility	Issuer of a Health Benefit plan as defined by NRS 695G.019	Public Employees' Benefits Program (PEBP)	Elect-in Entity, Organization or Third Party	
Carson City	\$729.43	\$0.00	\$9,603.79	\$0.00	\$0.00	\$10,333.22
Clark	\$0.00	\$0.00	\$11,593.04	\$0.00	\$0.00	\$11,593.04
Douglas	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Washoe	\$2,225.80	\$9,083.74	\$10,034.50	\$0.00	\$0.00	\$21,344.04
Statewide Total	\$2,955.23	\$9,083.74	\$31,231.33	\$0.00	\$0.00	\$43,270.30

Arbitrations for Claims of \$5,000 or More

For arbitrations of claims of \$5,000 or more, Out-of-Network Providers and Out-of-Network Emergency Facilities must request a list of five randomly selected arbitrators from the American Arbitration Association (AAA) or Judicial Arbitration and Mediation Services (JAMS).

Organizations conducting arbitrations for claims of \$5,000 or more are required to report on or before December 31 of each year to the Department of Health and Human Services on the form prescribed by OCHA.

Arbitrations Determined for Claims of \$5000 or more

Arbitrator	Prevailing Party - Provider		Prevailing Party - Third Party			Total
	Out-of-Network Provider	Out-of-Network Emergency Facility	Issuer of a Health Benefit plan as defined by NRS 695G.019	Public Employees' Benefits Program (PEBP)	Elect-in Entity or Organization	
AAA	0	0	0	0	0	0
JAMS	0	0	0	0	0	0
Total	0	0	0	0	0	0

JAMS reported no arbitrations were completed during this reporting period.

As of December 31, 2020, OCHA has not received arbitration information from AAA.

Provider of Health Care or Third Party Relevant Information

Report information is confidential pursuant to NRS 439B.760 (3.) (a) (1) and 439B.760 (4.). The provider of health care and/or Third Party relevant information is included (**Exhibit G: Provider of Health Care or Third Party Relevant Information**).

Provider and Third Party Contract Data

An analysis of the impact of actions taken pursuant to NRS 439B.700 to 439B.760, inclusive, on provider contracts and the provision of health care in this State, NRS 439B.760 (3.) (a) (1) (**Exhibit H: NRS 439B.760 Provider and Third Party Reporting Form**):

NRS 439B.700 to 439B.760 became effective January 1, 2020. Proposed regulation LCB File No. R101-19 includes Providers of medically necessary emergency service and Third Parties to report to OCHA the percentage of increase of contracts entered into and percentage of decrease of contracts (**Exhibit J: List of Election of Entities and Organization Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760**). As of December 31, 2020, providers of medically necessary emergency service and Third Parties report zero increase of contracts entered into and zero decrease in contracts. OCHA anticipates as more Out-of-Network Providers and Out-of-Facilities participate in the arbitration this would impact the increase of contracts entered into as well as the decrease in contracts. Additionally, as more arbitration cases are completed, this may impact a change in Provider fees and Third Party reimbursement rates.

Election by Entities and Organizations Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760

Entities or organizations not otherwise subject to the provisions of NRS 439B.700 to 439B.760 may elect to participate under these provisions by submitting an Election to Participate in NRS 439B form (**Exhibit I: Election to Participate in NRS 439B Form**). During calendar year 2020 twenty-six (26) entities or organizations elected to participate under the provisions of NRS 439B.700 (**Exhibit J: List of Election of Entities and Organization Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760**). Of these, none have elected to withdraw their participation (**Exhibit K: NRS 439B.757 Participation Withdrawal Form**).

Conclusion

In summary, for calendar year 2020 OCHA began receiving Request for Arbitration applications in March. OCHA continues collaborating with stakeholders to assist with the successful implementation of AB469. Additionally, proposed regulation LCB File No. R101-19 is pending final LCB review. After OCHA receives the revised draft regulations from LCB another public workshop will be scheduled. After the public workshop a hearing to adopt regulations will be scheduled. Upon adoption of the regulations OCHA anticipates receiving more Request for Arbitration applications.

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List of Exhibits

Exhibit A: [AB469 Codified NRS Chapter 439B](#)

Exhibit B: [Draft Proposed Regulation LCB File No. R101-19 \(Rev. 6/18/20\)](#)

Exhibit C: [OCHA Policy AB 469 Proposed Permanent Regulations \(Rev. 6/18/20\)](#)

Exhibit D: [OCHA NRS 439B.700 Arbitration Process Overview](#)

Exhibit E: [Request for Arbitration Claims Under \\$5,000 – Instructions](#)

Exhibit F: [Request for Arbitration Claims Under \\$5,000 – Application](#)

Exhibit G: [Provider of Health Care or Third Party Relevant Information](#)

Exhibit H: [NRS 439B.760 Provider and Third Party Reporting Form](#)

Exhibit I: [Election to Participate in NRS 439B Form](#)

Exhibit J: [List of Election of Entities and Organization Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760](#)

Exhibit K: [NRS 439B.757 Participation Withdrawal Form](#)

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Exhibit A: AB469 Codified NRS Chapter 439B

**AB469, 2019 Legislature
Effective January 1, 2020
Codified NRS Chapter 439B**

PAYMENT FOR MEDICALLY NECESSARY EMERGENCY SERVICES PROVIDED OUT-OF-NETWORK

NRS 439B.700 Definitions. [Effective January 1, 2020.] As used in [NRS 439B.700](#) to [439B.760](#), inclusive, unless the context otherwise requires, the words and terms defined in [NRS 439B.703](#) to [439B.739](#), inclusive, have the meanings ascribed to them in those sections.

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.703 “Covered person” defined. [Effective January 1, 2020.] “Covered person” means a policyholder, subscriber, enrollee or other person covered by a third party.

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.706 “Independent center for emergency medical care” defined. [Effective January 1, 2020.] “Independent center for emergency medical care” has the meaning ascribed to it in [NRS 449.013](#).

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.709 “In-network emergency facility” defined. [Effective January 1, 2020.] “In-network emergency facility” means a hospital or independent center for emergency medical care that is an in-network provider.

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.712 “In-network provider” defined. [Effective January 1, 2020.] “In-network provider” means, 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.

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.715 “Medically necessary emergency services” defined. [Effective January 1, 2020.] “Medically necessary emergency services” means 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.

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.718 “Out-of-network emergency facility” defined. [Effective January 1, 2020.] “Out-of-network emergency facility” means a hospital or independent center for emergency medical care that is an out-of-network provider.

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.721 “Out-of-network provider” defined. [Effective January 1, 2020.] “Out-of-network provider” means, 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.

(Added to NRS by [2019, 320](#), effective January 1, 2020)

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NRS 439B.724 “Provider contract” defined. [Effective January 1, 2020.] “Provider contract” means a contract between a third party and an in-network provider to provide health care services to a covered person.

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.727 “Provider of health care” defined. [Effective January 1, 2020.] “Provider of health care” has the meaning ascribed to it in [NRS 695G.070](#).

(Added to NRS by [2019, 320](#), effective January 1, 2020)

NRS 439B.730 “Prudent person” defined. [Effective January 1, 2020.] “Prudent person” means 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.

(Added to NRS by [2019, 321](#), effective January 1, 2020)

NRS 439B.733 “Screen” defined. [Effective January 1, 2020.] “Screen” means to conduct the medical screening examination required to be provided to a patient in the emergency department of a hospital pursuant to 42 U.S.C. § 1395dd.

(Added to NRS by [2019, 321](#), effective January 1, 2020)

NRS 439B.736 “Third party” defined. [Effective January 1, 2020.]

1. “Third party” 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 pursuant to [NRS 439B.757](#) for the provisions of [NRS 439B.700](#) to [439B.760](#), inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term 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 Department.

(Added to NRS by [2019, 321](#), effective January 1, 2020)

NRS 439B.739 “To stabilize” and “stabilized” defined. [Effective January 1, 2020.] “To stabilize” and “stabilized” have the meanings ascribed to them in 42 U.S.C. § 1395dd(e)(3).

(Added to NRS by [2019, 321](#), effective January 1, 2020)

NRS 439B.742 Inapplicability of provisions to certain hospitals, persons and health care services. [Effective January 1, 2020.] The provisions of [NRS 439B.745](#) and [439B.748](#) do not apply to:

1. A hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e) or any medically necessary emergency services provided at such a hospital;

2. A person who is covered by a policy of health insurance that was sold outside this State; or

3. Any health care services provided more than 24 hours after notification is provided pursuant to [NRS 439B.745](#) that a person has been stabilized.

(Added to NRS by [2019, 321](#), effective January 1, 2020)

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NRS 439B.745 Limitation on amount out-of-network provider may collect from covered person; duties of out-of-network emergency facility upon providing services. [Effective January 1, 2020.]

1. An out-of-network provider shall not collect from a covered person for medically necessary emergency services, and a covered person is not responsible for paying, an amount that exceeds the copayment, coinsurance or deductible required for such services provided by an in-network provider by the coverage for that person.

2. An out-of-network emergency facility that provides medically necessary emergency services to a covered person shall:

(a) When possible, notify the third party that provides coverage for the covered person not later than 8 hours after the covered person presents at the out-of-network emergency facility to receive medically necessary emergency services; and

(b) Notify the third party that the condition of the covered person has stabilized to such a degree that the person may be transferred to an in-network emergency facility not later than 24 hours after the person's emergency medical condition is stabilized. Not later than 24 hours after the third party receives such notice, the third party shall arrange for the transfer of the person to such a facility.

(Added to NRS by [2019, 321](#), effective January 1, 2020)

NRS 439B.748 Payment to out-of-network emergency facility by third party. [Effective January 1, 2020.]

1. If an out-of-network emergency facility had a provider contract as an in-network emergency facility within the 24 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage for the covered person shall pay to the out-of-network emergency facility for those services, and the out-of-network emergency facility shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network emergency facility:

(a) If the out-of-network emergency facility was an in-network emergency facility within the 12 months immediately preceding the provision of medically necessary emergency services, 108 percent of the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network emergency facility, less the amount of the copayment, coinsurance or deductible, if applicable.

(b) If the out-of-network emergency facility was an in-network emergency facility within the 24 months immediately preceding the provision of medically necessary emergency services, but not within the 12 months immediately preceding the provision of those services, 115 percent of the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network emergency facility, less the amount of the copayment, coinsurance or deductible, if applicable.

2. If an out-of-network emergency facility did not have a provider contract as an in-network emergency facility within the 24 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage to the covered person shall pay to the out-of-network emergency facility an amount that the third party has determined to be fair and reasonable as payment for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network emergency facility.

(Added to NRS by [2019, 322](#), effective January 1, 2020)

NRS 439B.751 Payment to out-of-network provider, other than emergency facility, by third party. [Effective January 1, 2020.]

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1. If an out-of-network provider, other than an out-of-network emergency facility, had a provider contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person and:

(a) The out-of-network provider terminated the most recent applicable provider contract between the third party that provides coverage for the covered person and the out-of-network provider without cause before it was scheduled to expire, the third party shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount that would have been paid for those services pursuant to that provider contract, less the amount of the copayment, coinsurance or deductible, if applicable.

(b) The out-of-network provider terminated the most recent applicable provider contract between the third party that provides coverage for the covered person and the out-of-network provider for cause before it was scheduled to expire or the third party terminated the contract without cause, the third party shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, 108 percent of the amount that would have been paid for those services pursuant to the provider contract, less the amount of the copayment, coinsurance or deductible, if applicable.

(c) The third party that provides coverage for the covered person terminated the most recent applicable provider contract between the third party and the out-of-network provider for cause before it was scheduled to expire, the third party shall pay to the out-of-network provider an amount that the third party has determined to be fair and reasonable as payment for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

(d) The contract was not terminated by either party, the third party that provides coverage for the covered person shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network provider plus an amount equal to the percentage of increase in the Consumer Price Index, Medical Care Component, during the immediately preceding calendar year, less the amount of the copayment, coinsurance or deductible, if applicable.

2. If an out-of-network provider, other than an out-of-network emergency facility, did not have a provider contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage to the covered person shall submit to the out-of-network provider an offer of payment in full for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

(Added to NRS by [2019, 322](#), effective January 1, 2020)

NRS 439B.754 Determination of amount owed when no recent contract exists between out-of-network provider and third party; arbitration to resolve dispute; no interest pending resolution of dispute; confidentiality of arbitration. [Effective January 1, 2020.]

1. An out-of-network provider shall accept or reject an amount paid pursuant to subsection 2 of [NRS 439B.748](#) or paragraph (c) of subsection 1 or subsection 2 of [NRS 439B.751](#) as payment in full for

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the medically necessary emergency services for which the payment was offered within 30 days after receiving the payment. If an out-of-network provider fails to comply with the requirements of this section, the amount paid shall be deemed accepted as payment in full for the medically necessary emergency services for which the payment was offered 30 days after the out-of-network provider received the payment.

2. If an out-of-network provider rejects the amount paid as payment in full, the out-of-network provider must request from the third party an additional amount which, when combined with the amount previously paid, the out-of-network provider is willing to accept as payment in full for the medically necessary emergency services.

3. If the third party refuses to pay the additional amount requested by the out-of-network provider pursuant to subsection 2 or fails to pay that amount within 30 days after receiving the request for the additional amount, the out-of-network provider must request a list of five randomly selected arbitrators from an entity authorized by regulations of the Director of the Department to provide such arbitrators. Such regulations must require:

(a) For claims of less than \$5,000, the use of arbitrators who will conduct the arbitration in an economically efficient manner. Such arbitrators may include, without limitation, qualified employees of the State and arbitrators from the voluntary program for the use of binding arbitration established in the judicial district pursuant to [NRS 38.255](#) or, if no such program has been established in the judicial district, from the program established in the nearest judicial district that has established such a program.

(b) For claims of \$5,000 or more, the use of arbitrators from nationally recognized providers of arbitration services, which may include, without limitation, the American Arbitration Association, JAMS or their successor organizations.

4. Upon receiving the list of randomly selected arbitrators pursuant to subsection 3, the out-of-network provider and the third party shall each strike two arbitrators from the list. If one arbitrator remains, that arbitrator must arbitrate the dispute concerning the amount to be paid for the medically necessary emergency services. If more than one arbitrator remains, an arbitrator randomly selected from the remaining arbitrators by the entity that provided the list of arbitrators pursuant to subsection 3 must arbitrate that dispute.

5. The out-of-network provider and the third party shall participate in binding arbitration of the dispute concerning the amount to be paid for the medically necessary emergency services conducted by the arbitrator selected pursuant to subsection 4. The out-of-network provider or third party may provide the arbitrator with any relevant information to assist the arbitrator in making a determination.

6. The arbitrator shall require:

(a) The out-of-network provider to accept as payment in full for the provision of the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount paid by 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; or

(b) The third party to pay the additional amount requested by the out-of-network provider pursuant to subsection 2.

7. If the arbitrator requires:

(a) The out-of-network provider to accept the amount paid by 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 provision of the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the out-of-network provider must pay the costs of the arbitrator.

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(b) The third party to pay the additional amount requested by the out-of-network provider pursuant to subsection 2, the third party must pay the costs of the arbitrator.

8. An out-of-network provider or a third party must pay its own attorney's fees incurred during the process prescribed by this section.

9. Interest does not accrue on any claim for which an offer of payment is rejected pursuant to subsection 1 for the period beginning on the date of the rejection and ending 30 days after the arbitrator renders a decision.

10. Except as otherwise provided in this subsection and [NRS 439B.760](#), any decision of an arbitrator pursuant to this section and any documents associated with such a decision are confidential and are not admissible as evidence during a legal proceeding, including, without limitation, a legal proceeding between the third party and the out-of-network provider. The decision of an arbitrator and any documents associated with such a decision may be disclosed and are admissible as evidence during a legal proceeding to enforce the decision.

(Added to NRS by [2019, 323](#), effective January 1, 2020)

NRS 439B.757 Election by certain entities and organizations not otherwise covered to submit to provisions; regulations. [Effective January 1, 2020.] Any entity or organization, not otherwise subject to the provisions of [NRS 439B.700](#) to [439B.760](#), inclusive, that provides coverage for emergency medical services, including, without limitation, a participating public agency, as defined in [NRS 287.04052](#), and any other local governmental agency which provides a system of health insurance for the benefit of its officers and employees, and the dependents of such officers and employees, pursuant to [chapter 287](#) of NRS, may elect for the provisions of [NRS 439B.700](#) to [439B.760](#), inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons. The Director of the Department of Health and Human Services shall:

1. Publish on an Internet website maintained by the Department a list of third parties that have made such an election; and
2. Adopt regulations governing such an election, which may include, without limitation, regulations that establish the procedure by which a third party may make such an election.

(Added to NRS by [2019, 325](#), effective January 1, 2020)

NRS 439B.760 Reports; confidentiality of information. [Effective January 1, 2020.]

1. On or before December 31 of each year, an arbitrator who arbitrated a matter pursuant to [NRS 439B.754](#) during the immediately preceding 12 months shall report to the Department of Health and Human Services in the form prescribed by the Department:

- (a) The number of cases arbitrated by the arbitrator;
- (b) The types of providers of health care and third parties involved in those cases;
- (c) The prevailing party in each such arbitration;
- (d) Information concerning the geographic location of the provider of health care that provided medically necessary emergency services; and
- (e) Any other information requested by the Department.

2. A provider of health care or third party:

- (a) Shall provide to the Department any information requested by the Department to complete the report required by subsection 3; and
- (b) May provide to the Department any other information relevant to that report.

3. On or before January 31 of each year, the Department shall:

- (a) Compile a report which consists of:
 - (1) Aggregated information provided to the Department pursuant to subsections 1 and 2, presented in a manner that does not reveal the identity of any provider of health care, third party or patient;

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- (2) An analysis of any identifiable trends in the information described in subparagraph (1); and
- (3) An analysis of the impact of actions taken pursuant to [NRS 439B.700](#) to [439B.760](#), inclusive, on provider contracts and the provision of health care in this State;
- (b) Post the report on an Internet website maintained by the Department; and
- (c) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to:
 - (1) In even-numbered years, the Legislative Committee on Health Care; and
 - (2) In odd-numbered years, the next regular session of the Legislature.
- 4. Any information disclosed to the Department pursuant to this section is confidential.
(Added to NRS by [2019, 325](#), effective January 1, 2020)

List of Exhibits

Department of Health and Human Services
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Exhibit B: Draft Proposed Regulation LCB File No. R101-19 (Rev. 6/18/20)

STEVE SISOLAK
Governor



RICHARD WHITLEY, MS
Director

CARRIE EMBREE, LSW
Governor's Consumer Health Advocate

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CONSUMER HEALTH ASSISTANCE
Governor's Consumer Health Advocate
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June 18, 2020
OCHA's Revised Draft of Proposed Regulations
LCB File No. R101-19

Section 1. Chapter 439B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this regulation.

Sec. 2. 1. *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, an out-of-network provider must submit a request to the Department. 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:*

(a) 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.

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

2. A request submitted pursuant to subsection 1 must be in the form prescribed by the

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Department 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. ~~A representative sample of at least three payments received by the out-of-network provider as compensation for the same medically necessary emergency services provided in the same region of this State from third parties with which the out-of-network provider has not entered into a provider contract.~~

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3. *If the Department 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 5 10 business days after receiving a request pursuant to subsection 1, the Department shall notify the out-of-network provider in writing of the receipt of the request. Not later than 15 20 business days after the written notification of the receipt of the request, the Department shall 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.

4. *The Department 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 Department 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 Department who are qualified to arbitrate the dispute.

Sec. 3. 1. *Not later than 10 business days from the date the written ~~after receiving a~~*

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list of arbitrators is provided by the Department pursuant to subsection 5 of section 2 of this regulation, the out-of-network provider and third party shall strike arbitrators from the list in the manner required by subsection 4 of NRS 439B.754 and provide the ~~name of~~ names of any the remaining ~~arbitrator~~ arbitrators on the list in writing to the Department.

2. Not later than 5 10 business days after receiving the ~~name~~ names of any the remaining ~~arbitrator~~ arbitrators on the list pursuant to subsection 1, the Department 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 Department notifies the out-of-network provider and the third party in writing of the name of the arbitrator.

3. An arbitrator selected pursuant to subsection 2 ~~shall~~ 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 ~~after-receiving~~ the request. If either party fails to provide information requested by the arbitrator within that

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time, the arbitrator may proceed and make a determination based on the evidence available to the arbitrator.

4. Not later than ~~30~~ 45 business days after the expiration of the period for submission of the information-receiving-information pursuant to subsection 2, paragraph (d), or subsection 3, as applicable or, if the information is not provided, not later than 30 days after the expiration of the period for submission of the information, as applicable, the arbitrator shall make a determination as provided in subsection 6 of NRS 439B.754 and notify the parties of that determination.

Sec. 4. An out-of-network provider that wishes 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 must request a list of five randomly selected arbitrators from:

- 1. The American Arbitration Association or its successor organization; or*
- 2. JAMS or its successor organization.*

Sec. 5. 1. 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, 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;*
- (b) A description of the type of entity or organization, as applicable, that it is; and*
- (c) ~~The date on which the entity or organization requests the election to become effective.~~*

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

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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 ~~30~~ 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.*

Sec. 6. 1. On or before December 31 of each year, each provider of medically necessary emergency services in this State shall submit requested information for the immediately preceding 12 months 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*

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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 requested information for the immediately preceding 12 months to the Department in the form prescribed by the Department:

(a) ~~1.~~—The name of and contact information for the third party;

(b) ~~2.~~—A description of the type of third party that it is;

~~3.—The number of disputed payments for medically necessary emergency services provided by out-of-network providers that were settled without arbitration during the immediately preceding year and, for each such payment, the type of out-of-network provider and the amount of the payment;~~

(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 ~~that were terminated during the immediately preceding year and the reasons for each termination.~~

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Exhibit C: OCHA Policy AB 469 Proposed Permanent Regulations (Rev. 6/18/20)

DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE FOR CONSUMER HEALTH ASSISTANCE POLICY				
POLICY #	REVISED	TITLE	EFFECTIVE DATE	PAGE
	6/18/2020	AB 469 Proposed Permanent Regulations	1/1/2020	1 of 7

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.

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“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”

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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.

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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. ARBITRATOR 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

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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

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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

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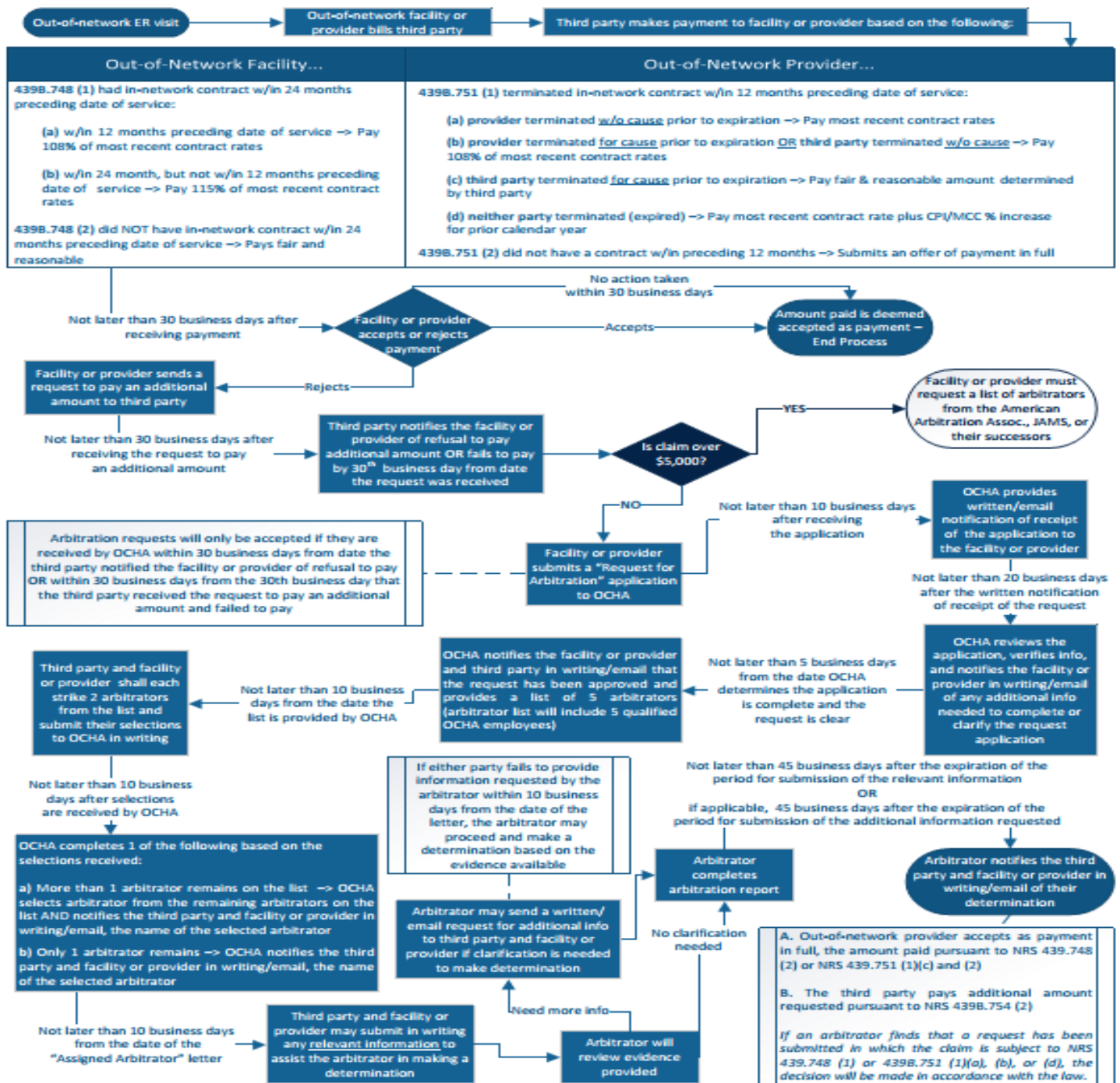
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- d. Whether there was a decrease in the number of provider contracts between the third party and providers of medically necessary emergency services and the percentage of the decrease from the immediately preceding year.

List of Exhibits

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Exhibit D: OCHA NRS 439B.700 Arbitration Process Overview

NRS 439B.700: Arbitration Process Overview – DRAFT 06.18.20



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Exhibit E: Request for Arbitration Claims Under \$5,000 – Instructions

Instructions for completing an Office for Consumer Health Assistance
Request for Arbitration application for claims under \$5,000.00

Instructions Section 1: To be completed by the Provider/Facility prior to submitting a Request for Arbitration

Before submitting a Request for Arbitration verify each of the following:

1. **The Third Party, that is associated with the claim, is an issuer of a Health Benefit plan as defined by NRS 695G.019, a Public Employees' Benefits Program (PEBP), and/or self-funded and has opted to participate in the provisions of NRS 439B.754.**
 - To verify if the Third Party has opted into the provisions of NRS 439B.754, please review the [Third Party Opt-In List](http://dhhs.nv.gov/Programs/CHA/ThirdPartyOptInList) on the Office for Consumer Health Assistance website:
<http://dhhs.nv.gov/Programs/CHA/>
2. **The policy that is associated with the claim was sold within the state of Nevada.**
3. **The Provider/Facility was an Out-of-Network Provider (i.e. not contracted) with the Third Party on the date the medically necessary emergency services were provided.**
4. **With the Third Party, the arbitration contact information, to include:**
 - Third Party Arbitration Contact name
 - Third Party Arbitration Contact phone number
 - Third Party Arbitration Contact email address
5. **The total amount billed for the entire claim is less than \$5,000.00.**
6. **The Out-of-Network Provider/Facility requested the additional amount from the Third Party within 30 business days after receiving initial payment.**
 - **For example:** The Out-of-Network Provider/Facility received the initial payment for the claim from the Third Party on 07/01/2020. Therefore, the Provider/Facility must request the additional amount from the Third Party on or before 8/12/2020 (30 business days later).
7. **The Out-of-Network Provider/Facility submits a request for arbitration if the Third Party *refuses* to pay the additional amount requested by the Out-of-Network Provider/Facility or *fails* to pay that amount within 30 business days after receiving the request for the additional amount.**
 - a) ***Refusal to pay Submission Timeframe:*** Request for Arbitration must be submitted not later than 30 business days from the date the Third Party notified the Provider/Facility of their ***refusal*** to pay the additional amount requested.
 - ❖ **Example:** The Provider has documentation with a date of 07/10/2020 from the Third Party refusing to pay the additional amount requested. The Request for Arbitration must be submitted between 07/10/2020 and 30 business days from 07/10/2020, which is 08/21/2020. Documentation showing proof of refusal to pay with a date of 07/10/2020 must be submitted with the application. The Request for Arbitration is invalid if submitted after 8/21/2020.
 - OR
 - b) ***Failure to pay Submission Timeframe:*** Request for Arbitration must be submitted not later than 30 business days from the date the Provider/Facility requested the additional amount from the Third Party and the Third Party ***failed*** to respond to the request.
 - ❖ **Example:** The request for the additional payment was submitted to the Third Party on 07/15/2020. The Third Party failed to respond to this request to pay the additional amount within 30 business days, i.e. by 08/26/2020. A Request for Arbitration submitted prior to 8/26/2020 is invalid.

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Instructions for completing an Office for Consumer Health Assistance
 Request for Arbitration application for claims under \$5,000.00

Instructions Section 2: Completing the Request for Arbitration Application

1. Visit the Office for Consumer Health Assistance website to ensure the most up to date application is completed; [Request for Arbitration Claims Under \\$5,000](#). As the arbitration process evolves, the Office for Consumer Health Assistance continues to make revisions as identified in the processing of applications and feedback received.
2. To be considered complete, all fields on the application must be completed and all supporting documentation submitted must be consistent with information entered on the application. Any discrepancies between the supporting documentation and the application will be returned to the Out-of-Network Provider/Facility for clarification.
 - For example: the date on the documentation submitted as proof of the date the Provider requested additional payment must match the date submitted on the application.

Instructions Section 3: Sample Application

CONFIDENTIAL

Pursuant to NRS 439B.754 (10), except as otherwise provided, any decision of an arbitrator and any documents associated with such a decision are confidential.

**REQUEST FOR ARBITRATION
 CLAIMS UNDER \$5,000**

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, an out-of-network provider must submit a request to the Department. 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 not later than 30 business days after:

- a) The date on which the third party notifies the out-of-network provider of the refusal to pay the additional amount.
- b) The third party failed to pay the additional amount for 30 business days after receiving a request for the additional amount.

PROVIDER/FACILITY INFORMATION

Provider type for which the arbitration application is being submitted:

Out-of-Network Provider (OONP) Out-of-Network Facility (OONF)

Provider/Facility Name:	Provider/Facility DBA:
Provider Type and Specialty (OONP only):	Address for the location where the medically necessary emergency services were provided:
Provider/Facility Phone:	
Provider/Facility Fax:	
Provider/Facility Email:	
Has the Provider/Facility ever contracted with the Third Party? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, date contract terminated (month/ year):

This field does not apply to facilities.

Enter the physical address where the services were provided.

If "Yes" is checked, enter the month and year in the box to the right.

PROVIDER/FACILITY ARBITRATION CONTACT

Provider/Facility Contact Name:	Provider/Facility Contact Mailing Address:
Provider/Facility Contact Phone:	Provider/Facility Contact Email:
Provider/Facility Contact Fax:	

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Instructions for completing an Office for Consumer Health Assistance
 Request for Arbitration application for claims under \$5,000.00

THIRD PARTY INFO & ARBITRATION CONTACT

Third parties must meet the criteria as defined in NRS 439B.736 to participate in the provisions of NRS 439B.700 to NRS 439B.760. If at any point during the arbitration process, the Office for Consumer Health Assistance determines that the Third Party is inapplicable to these provisions, the request for arbitration will be denied.

This contact information is specific to the person who handles Arbitrations.

Third Party Name:	Third Party Type: Selection Required*
Third Party Arbitration Contact Name:	Third Party Arbitration Contact Mailing Address:
Third Party Arbitration Contact Phone:	
Third Party Arbitration Contact Email Address:	

Click here to select an option from the dropdown.

No other information should be entered in this field.

DISPUTE INFORMATION

Only one claim, per patient, can be submitted per Arbitration Request; however, multiple CPT or HCPCS codes can be disputed on a single claim. For plans that elect to participate in provisions of NRS 439B.700 to 439B.760, only dates of service that fall on or after the third party participation effective date are eligible for arbitration.

SINGLE CLAIM INFORMATION:

Claim Date(s) of Service:	Claim Number:	Insured's ID Number:	Patient Account Number:
Total Amount Billed for Claim:	Total Allowed Amount for Claim:	Date Initial Payment Received for Claim:	
Date Provider/Facility requested additional payment from the Third Party:		Total additional amount requested by Provider/Facility for Claim:	
Description of Dispute (Use additional pages if necessary):			
The Description of Dispute should be as detailed as possible . The Out-of-Network Provider/Facility may submit additional pages/documentation with this application to provide rationale that supports the request for additional payment.			

This field helps the Third Party to identify the claim.

Enter the total amount Third Party has allowed for the **entire claim**.

Enter the date **Initial** payment for the claim was received from the Third Party.

Enter the total amount billed for the **entire claim**, inclusive of all lines on the claim.

This amount must be under \$5,000.

SPECIFIC CPT or HCPCS CODE INFORMATION:

Please provide the following information for each CPT or HCPCS code the Provider/Facility would like to dispute on the single claim referenced above:

CPT or HCPCS Code:	Modifier:	Billed Amount:	Allowed Amount:	Copayment, Coinsurance, or Deductible:	Additional Amount Requested:

Example:

These fields are specific to **each code** the Provider/Facility wishes to dispute on the claim.

All fields must be completed for each code entered.

CPT or HCPCS Code:	Modifier:	Billed Amount:	Allowed Amount:	Copayment, Coinsurance or Deductible:	Additional Amount Requested:
99283		\$1784.00	\$380.56	\$250.00	\$921.10
80307	59	\$2415.00	\$603.75	\$603.75	\$1086.75

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Instructions for completing an Office for Consumer Health Assistance
 Request for Arbitration application for claims under \$5,000.00

In addition to this application form, Out-of-Network Providers/Facilities MUST submit documentation providing proof of the following:

Acceptable documents may include but are not limited to: corresponding dates, official addresses to and from, information pertaining to the claim.

Emails/Digital correspondence is acceptable.

1. The date on which the Out-of-Network Provider/Facility received initial payment from the Third Party and the amount of payment received;
2. The date on which the Out-of-Network Provider/Facility requested additional amount to be paid by the Third Party and the additional amount requested;
3. Provide the date the Third Party refused to pay the additional amount requested, **OR** if the Third Party failed to pay the additional amount, check the box below:

If the Third Party notified the Provider of refusal to pay, enter the date on which the refusal was received.

OR

Date Third Party Notified Provider of Refusal to Pay: _____

No response received from Third Party

If the Third Party failed to respond to the request to pay the additional amount not later than 30 business days from the date the Provider /Facility submitted the request, check the box.

If at any point during the arbitration process, the Office for Consumer Health Assistance determines that the hospital, person, or health care services, included in the request, are inapplicable to the provisions of NRS 439B.745 and 439B.748, the request for arbitration will be denied.

Pursuant to NRS 439B.742, the provisions of NRS 439B.745 and 439B.748 do not apply to:

1. A hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e) or any medically necessary emergency services provided at such a hospital;
2. A person who is covered by a policy of health insurance that was sold outside this State; or
3. Any health care services provided more than 24 hours after notification is provided pursuant to NRS 439B.745 that a person has been stabilized.

 Provider/Facility Name or Designee (please print)

 Signature

 Date

Return the completed application and supporting documentation to:

Office for Consumer Health Assistance
 Attn: Consumer Health Advocacy Specialist
 3320 W. Sahara Ave., Suite 100
 Las Vegas, Nevada 89102

Application may also be sent by Fax: (702) 486-3586 or Email: CHA@govcha.nv.gov

For any questions or assistance, contact the Office for Consumer Health Assistance at (702) 486-3587 or toll free at (888) 333-1597.

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Exhibit F: Request for Arbitration Claims Under \$5,000 – Application



STATE OF NEVADA
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Consumer Health Assistance
 Bureau for Hospital Patients
 3320 W. Sahara Avenue, Suite 100 | Las Vegas, Nevada 89102
 Phone: (702) 486-3587 | Toll Free: (888) 333-1597 | Fax: (702) 486-3586 | E-mail: cha@govcha.nv.gov

FOR OFFICE USE ONLY
OCHA CASE # _____
RECEIVED BY: _____
DATE: _____

CONFIDENTIAL

Pursuant to NRS 439B.754 (10), except as otherwise provided, any decision of an arbitrator and any documents associated with such a decision are confidential.

**REQUEST FOR ARBITRATION
 CLAIMS UNDER \$5,000**

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, an out-of-network provider must submit a request to the Department. 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 not later than 30 business days after:

- a) The date on which the third party notifies the out-of-network provider of the refusal to pay the additional amount.
- b) The third party failed to pay the additional amount for 30 business days after receiving a request for the additional amount.

PROVIDER/FACILITY INFORMATION

Provider type for which the arbitration application is being submitted:

- Out-of-Network Provider (OONP) Out-of-Network Facility (OONF)

Provider/Facility Name:	Provider/Facility DBA:
Provider Type and Specialty (OONP only):	Address for the location where the medically necessary emergency services were provided:
Provider/Facility Phone:	
Provider/Facility Fax:	
Provider/Facility Email:	
Has the Provider/Facility ever contracted with the Third Party? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, date contract terminated (month/ year):

PROVIDER/FACILITY ARBITRATION CONTACT

Provider/Facility Contact Name:	Provider/Facility Contact Mailing Address:
Provider/Facility Contact Phone:	
Provider/Facility Contact Fax:	Provider/Facility Contact Email:

CONFIDENTIAL

THIRD PARTY INFO & ARBITRATION CONTACT

Third parties must meet the criteria as defined in NRS 439B.736 to participate in the provisions of NRS 439B.700 to NRS 439B.760. If at any point during the arbitration process, the Office for Consumer Health Assistance determines that the Third Party is inapplicable to these provisions, the request for arbitration will be denied.

Third Party Name:	Third Party Type: Selection Required*
Third Party Arbitration Contact Name:	Third Party Arbitration Contact Mailing Address:
Third Party Arbitration Contact Phone:	
Third Party Arbitration Contact Email Address:	

DISPUTE INFORMATION

Only one claim, per patient, can be submitted per Arbitration Request; however, multiple CPT or HCPCS codes can be disputed on a single claim. For plans that elect to participate in provisions of NRS 439B.700 to 439B.760, only dates of service that fall on or after the third party participation effective date are eligible for arbitration.

SINGLE CLAIM INFORMATION:

Claim Date(s) of Service:	Claim Number:	Insured's ID Number:	Patient Account Number:
Total Amount Billed for Claim:	Total Allowed Amount for Claim:	Date Initial Payment Received for Claim:	
Date Provider/Facility requested additional payment from the Third Party:		Total additional amount requested by Provider/Facility for Claim:	
Description of Dispute (Use additional pages if necessary):			

SPECIFIC CPT or HCPCS CODE INFORMATION:

Please provide the following information for each CPT or HCPCS code the Provider/Facility would like to dispute on the single claim referenced above:

CPT or HCPCS Code:	Modifier:	Billed Amount:	Allowed Amount:	Copayment, Coinsurance, or Deductible:	Additional Amount Requested:

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(Continued) SPECIFIC CPT or HCPCS CODE INFORMATION:

Please provide the following information for each additional CPT or HCPCS code the Facility would like to dispute on the single claim referenced above:

CPT or HCPCS Code:	Modifier:	Billed Amount:	Allowed Amount:	Copayment, Coinsurance, or Deductible:	Additional Amount Requested:

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CONFIDENTIAL

In addition to this application form, Out-of-Network Providers/Facilities MUST submit documentation providing proof of the following:

1. The date on which the Out-of-Network Provider/Facility received initial payment from the Third Party and the amount of payment received;
2. The date on which the Out-of-Network Provider/Facility requested additional amount to be paid by the Third Party and the additional amount requested;
3. Provide the date the Third Party refused to pay the additional amount requested, **OR** if the Third Party failed to pay the additional amount, check the box below:

Date Third Party Notified Provider of Refusal to Pay:

No response received from Third Party

If at any point during the arbitration process, the Office for Consumer Health Assistance determines that the hospital, person, or health care services, included in the request, are inapplicable to the provisions of NRS 439B.745 and 439B.748, the request for arbitration will be denied.

Pursuant to NRS 439B.742, the provisions of NRS 439B.745 and 439B.748 do not apply to:

1. A hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e) or any medically necessary emergency services provided at such a hospital;
2. A person who is covered by a policy of health insurance that was sold outside this State;
or
3. Any health care services provided more than 24 hours after notification is provided pursuant to NRS 439B.745 that a person has been stabilized.

Provider/Facility Name or Designee (please print)

Signature

Date

Return the completed application and supporting documentation to:

Office for Consumer Health Assistance
Attn: Consumer Health Advocacy Specialist
3320 W. Sahara Ave., Suite 100
Las Vegas, Nevada 89102

Application may also be sent by Fax: (702) 486-3586 or Email: CHA@govcha.nv.gov

For any questions or assistance, contact the **Office for Consumer Health Assistance** at **(702) 486-3587** or toll free at **(888) 333-1597**.

List of Exhibits

Department of Health and Human Services
Office for Consumer Health Assistance
Payment for Medically Necessary Emergency Services Provided Out-of-Network
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Exhibit G: Provider of Health Care or Third Party Relevant Information

December 31, 2020

TRANSMITTED VIA ELECTRONIC MAIL

Carrie Embree
Governor's Consumer Health Advocate
Nevada Department of Health and Human Services
Aging and Disability Services Division
3320 West Sahara Ave, Suite 100
Las Vegas Nevada 89102

Dear Ms. Embree:

on behalf of members is providing claims information from pursuant to NRS 439B.760(2)(b) related to out of network emergency services covered under NRS 439B.700 through NRS 439B.760 inclusively. The information is being provided to the Office of Consumer Health Advocate (OCHA's) for inclusion in its annual reporting requirement to the Nevada Legislature.

Below is a summary of the limited information collected to date:

Calendar Year 2020

Claims that fell under AB 469: 1,750
Claims submitted for arbitration: 57 (3% of total AB 469 claims - submitted as of 12/15/20)

Under \$5,000 to OCHA

43
Rejected for technical reasons 24 (56% of claims submitted)
Pending arbitration 12 (28% of claims submitted)
Arbitration complete 7 (16% of claims submitted)
(4 in favor of /3 in favor of payers)

Over \$5,000 to AAA or JAM

14
Arbitration complete 0 (0% of claims submitted)

Recognizing January 1, 2020 was the effective date of the legislation much of the OCHA process regarding arbitrating claims has been developed during calendar year 2020; the regulations have not been finalized as of this report. Therefore, it is to be expected that the data collected for calendar year 2020 is incomplete.

In addition, acknowledges during the creation of the legislation, known as AB 469, stakeholders were aware physicians would have larger numbers of out of network emergency claims than hospitals. In an emergency - patients, family members and the ambulance service are focused on getting the patient to a contracted or in-network hospital (except in the most extreme circumstances when the patient is taken to the closest hospital for lifesaving care). The limited data reported has 1,750 claims qualified under the criteria of NRS 439B.700 et seq.

notes that only 3% of claims (57) have been submitted for arbitration. It is our belief this is due to lack of finalized regulations to guide the process. also would like to highlight the high rate of claim rejection for technical reasons (56% of claims submitted less than \$5,000).

Challenges also exist with arbitration requests for claims greater than \$5,000. has heard from members, who have submitted claims to either AAA or JAMS, arbitrators assigned by these associations did not have familiarity with the requirements found in the statute. asks OCHA and/or the Department of Health and Human Services (DHHS) under their obligation to "authorize by regulations" entities that

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will ensure all arbitrators of out of network emergency claims understand the statutory framework of NRS 439B.754.

looks forward to 2021 and greater clarity in the process to ensure a higher rate of claim resolution. Please feel free to contact either myself or , if there are questions pertaining to the information provided.

Sincerely,

-

Department of Health and Human Services
 Office for Consumer Health Assistance
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Exhibit H: NRS 439B.760 Provider and Third Party Reporting Form



STATE OF NEVADA
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Consumer Health Assistance
 Bureau for Hospital Patients
 3320 W. Sahara, Suite 100 | Las Vegas, Nevada 89102
 Phone: (702) 486-3587 | Toll Free (888) 333-1597
 Fax: (702) 486-3586 | E-mail: cha@govcha.nv.gov

FOR OFFICE USE ONLY
RECEIVED BY: _____
DATE: _____

NRS 439B.760 Provider & Third Party Reporting Form

Pursuant to NRS 439B.760, on or before December 31 of each year, a provider of health care or third party shall provide to the Department any information requested by the Department to complete the report required by NRS 439B.760.

Indicate the type of entity or organization submitting the report information:

- Provider** (complete sections 1 & 2 of the form) **Third Party** (complete sections 1 & 3 of the form)

Section 1: Contact Information

Provider or Third Party Name:	DBA (if applicable):
Mailing Address:	Physical Address:
Provider or Third Party Type:	Provider or Third Party Phone:
Contact Person:	Contact Phone:
Contact Email:	Contact Fax:

Section 2: Provider Data

	NO	YES	If YES, provide percentage difference from preceding year:
As a provider of medically necessary emergency services, has there been a decrease in the number of third party contracts entered into from the immediately preceding year?	<input type="checkbox"/>	<input type="checkbox"/>	0%
As a provider of medically necessary emergency services, has there been an increase in the number of <u>new</u> third party contracts entered into from the immediately preceding year?	<input type="checkbox"/>	<input type="checkbox"/>	0%
Provide the types of third parties for whom the <u>new</u> third party contracts were entered into:			

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Section 3: Third Party Data

	NO	YES	If YES, provide percentage difference from preceding year:
Has there been a decrease in the number of provider contracts the third party has entered into with providers of medically necessary emergency services from the immediately preceding year?	<input type="checkbox"/>	<input type="checkbox"/>	
Has there been an increase in the number of <u>new</u> provider contracts the third party has entered into with providers of medically necessary emergency services from the immediately preceding year?	<input type="checkbox"/>	<input type="checkbox"/>	
Provide the types of providers for whom the <u>new</u> provider contracts were entered into:			

Provider, Third Party, or Designee (please print)

Title

Signature

Date

Submit form to:

Office for Consumer Health Assistance
 Attn: Consumer Health Advocacy Specialist
 3320 W. Sahara Ave, Suite 100
 Las Vegas, Nevada 89102

Documents may also be sent by Fax: (702) 486-3586 or Email: CHA@govcha.nv.gov

For any questions or assistance, contact the **Office for Consumer Health Assistance** at (702) 486-3587 or toll free at (888) 333-1597.

List of Exhibits

Department of Health and Human Services
 Office for Consumer Health Assistance
 Payment for Medically Necessary Emergency Services Provided Out-of-Network
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Exhibit I: Election to Participate in NRS 439B Form



STATE OF NEVADA
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Consumer Health Assistance
 Bureau for Hospital Patients
 3320 W. Avenue, Suite 100 | Las Vegas, Nevada 89102
 Phone: (702) 486-3587 | Toll Free (888) 333-1597
 Fax: (702) 486-3586 | E-mail: cha@govcha.nv.gov

Election to Participate in NRS 439B

A third party that is not otherwise subject to the provisions of NRS 439B.757, may choose to elect to participate in the provisions of NRS 439B by submitting this form to the Office for Consumer Health Assistance.

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.

Third Party Name:	DBA (if applicable):
Third Party Type: <small>Self-funded plan that elects to the provisions of NRS 439B.700 to 439B.760</small>	Customer Service Phone – Eligibility/Claims:

Notification/Transfer & Stabilization Contact Information

Primary Contact Name:	Secondary Contact Name (optional):
Primary Contact Phone:	Secondary Contact Phone:
Primary Email Address:	Secondary Email Address:

Contact Information for Arbitration

Contact Name:	Title:
Phone:	Mailing Address:
Email Address:	

Third Party or Designee (please print)

Title

Signature

Date

Email

Phone

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Exhibit J: List of Election of Entities and Organization Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760

**Election by Entities and Organizations not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760
As of January 14, 2021**

	Third Party Name	d/b/a (If applicable)	Third Party Type	Customer Service Phone Number - Eligibility/Claims	Notifications/Transfer & Stabilization Primary Contact	Secondary Contact	Contact Information for Arbitration Disputes	Mailing Address	Participation Effective Date	Opt-Out Date
1	Culinary Health Fund		Self-Insured Taft-Hartley Health Plan	702-733-9938	Nancy Nikolski 702-892-7338 Cell: 702-281-8014 Fax: 702-735-1649 nnikolski@culinaryhealthfund.org		Cindy Pearson 702-691-5602 cpearson@culinaryhealthfund.org	1901 Las Vegas Blvd S. Suite 101 Las Vegas, NV 89104	1/1/2020	
2	Clark County Firefighters Local Union 1908 Security Fund			800-777-3575	Nicole Powell 800-777-3575, Ext 1492 npowell@ebms.com		Nicole Powell 800-777-3575, Ext 1492 npowell@ebms.com	EBMS PO Box 21367 Billings, MT 59104-1367	1/1/2020	
3	North Las Vegas Firefighters Union Health & Welfare Fund				Cindy Matthews 330-834-2302 cmatthews@healthplan.org			4040 Losee Road North Las Vegas, NV 89030	1/1/2020	
4	Banner Health		Self-Insured Employer ERISA Plan	855-788-5803	David J. Schuitema, CEBS 602-747-7984 david.schuitema@bannerhealth.com	Ashely Allen 602-747-8135 ashely.allen@bannerhealth.com	Frank Kyle 801-933-3538 fkyle@aetna.com	10150 S. Centennial Pkwy Suite 450 Sandy, UT 84070	4/15/2020	
5	Atlantis Casino Resort & Spa		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists- HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	4/15/2020	
6	City of Reno		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists- HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	4/15/2020	
7	Peppermill Casino, Inc		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists- HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	4/15/2020	
8	Douglas County School District		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists- HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	4/15/2020	
9	Washoe County Self-Funded Group Health Plan		Local Government	775-328-2088	Ashley Berrington 775-328-2088 aberrington@washoecounty.us	Kristie Harmon 775-328-2079 kharmon@washoecounty.us	Ashley Berrington 775-328-2088 aberrington@washoecounty.us	1001 E. 9th Street Reno, NV 89512	5/1/2020	
10	Renown Health		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists- HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	5/1/2020	
11	Teamsters Local 631 Security Fund for Southern Nevada		Self-Funded Health Plan	702-415-2185	Nancy Nikolski 702-283-2421 nnikolski@culinaryhealthfund.org		Kayla Harmer, Plan Manager 702-415-2180 x7316 kayla.harmer@benesys.com	BeneSys Administrators Attn: Kayler Harmer 8311 W. Sunset Rd., Suite 250 Las Vegas, NV 89113	5/1/2020	

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	Third Party Name	d/b/a (if applicable)	Third Party Type	Customer Service Phone Number - Eligibility/Claims	Notifications/Transfer & Stabilization Primary Contact	Secondary Contact	Contact Information for Arbitration Disputes	Mailing Address	Participation Effective Date	Opt-Out Date
12	Plumbers & Pipefitters Local 525 Health & Welfare Fund		Self-Funded Health Plan	702-415-2199	Chanelle Bergren 614-933-6606 BergrenC1@ahhinc.com		Denise Best, Plan Manager 702-415-2180, Ext. 7319 denise.best@benesys.com	BeneSys Administrators Attn: Kayler Harmer 8311 W. Sunset Rd., Suite 250 Las Vegas, NV 89113	5/1/2020	
13	Cement Masons and Plasterers Health and Welfare Trust		Multi-Employer ERISA Health and Welfare Plan	702-415-2190	Innovative Care Management, Inc (Pre-Authorization Dept.) 503-654-9447 onlineprecert@innovativecare.com	Kayla Harmer, Plan Manager 702-415-2180 x7316 kayla.harmer@benesys.com	Kayla Harmer, Plan Manager 702-415-2180 x7316 kayla.harmer@benesys.com	BeneSys Administrators Attn: Kayler Harmer 8311 W. Sunset Rd., Suite 250 Las Vegas, NV 89113	5/1/2020	
14	Las Vegas Firefighters		Self-Funded	844-711-3473	Chanelle Bergren 614-933-6606 BergrenC1@ahhinc.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	5/1/2020	
15	Teamsters Security Fund Southern Nevada Hotel & Casino Workers	Teamsters Local 986	Health & Welfare Trust Fund	702-734-8601	Danielle Galuppi 702-853-9605 dgaluppi@zenith-american.com	Cecilia Bacero 702-682-9044 cbacero@teamstershvwfund.com	Danielle Galuppi, Client Services Executive 702-853-9605 dgaluppi@zenith-american.com	2200 S. Rancho Blvd. Ste 295 Las Vegas, NV 89102	5/1/2020	
16	Electrical Workers Local 357 Health and Welfare Trust		Self-Funded Health Plan	702-415-2188	Innovative Care Management, Inc (Pre-Authorization Dept.) 503-654-9447 onlineprecert@innovativecare.com	Denise Best 702-415-2180, Ext. 7319 denise.best@benesys.com	Denise Best, Plan Manager 702-415-2180, Ext. 7319 denise.best@benesys.com	IBEW Local 357 H&W Fund Attn: Denise Best 8311 W. Sunset Rd., Ste. 205 Las Vegas, NV 89113	6/1/2020	
17	Lander County School District		Self-Funded Health Plan	775-352-6900	Russell Klein 775-635-5347 rklein@landernv.nt		Russell Klein, Superintendent 775-635-5347 rklein@landernv.nt	P.O. Box 1300 Battle Mountain, NV 89820	6/15/2020	
18	Meruelo, LLC	Grand Sierra Resort	Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists- HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	7/1/2020	
19	El Dorado Resorts, Inc.		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists- HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	8/1/2020	
20	City of Sparks		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists- HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	8/1/2020	
21	Edwards Lifesciences		Self-Funded Plan	800-955-1237	Provider Service Center 888-632-3862		Frank Kyle 801-933-3538 Fkyle@aetna.com	Aetna c/o Compliance 10150 S. Centennial Pkwy. Suite 450 Sandy, UT 84070	10/1/2020	

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	Third Party Name	d/b/a (If applicable)	Third Party Type	Customer Service Phone Number - Eligibility/Claims	Notifications/Transfer & Stabilization Primary Contact	Secondary Contact	Contact Information for Arbitration Disputes	Mailing Address	Participation Effective Date	Opt-Out Date
22	Lululemon USA		Self-Funded Plan	888-325-2439	Provider Service Center 888-632-3862		Frank Kyle, Sr. Market Compliance Consultant 801-933-3538 fkyle@aetna.com	Aetna c/o Compliance 10150 S. Centennial Pkwy. Suite 450 Sandy, UT 84070	10/15/2020	
23	Xylem, Inc.		Self-Funded Plan	866-991-0369	Aetna Provider Service Center 888-632-3862		Frank Kyle, Sr. Market Compliance Consultant 801-933-3538 fkyle@aetna.com	Aetna c/o Compliance 10150 S. Centennial Pkwy. Suite 450 Sandy, UT 84070	12/1/2020	
24	SWIFT		Self-Funded Plan	540-829-1326	Aetna Provider Service Center 888-632-3862		Frank Kyle, Sr. Market Compliance Consultant 801-933-3538 fkyle@aetna.com	Aetna c/o Compliance 10150 S. Centennial Pkwy. Suite 450 Sandy, UT 84070	12/15/2020	
25	The Nature Conservancy		Self-Funded Plan	800-962-6842	Aetna Provider Service Center 888-632-3862		Frank Kyle, Sr. Market Compliance Consultant 801-933-3538 fkyle@aetna.com	Aetna c/o Compliance 10150 S. Centennial Pkwy. Suite 450 Sandy, UT 84070	1/1/2021	
26	Clarke Environmental Mosquito Management, Inc.		Self-Funded Plan	888-632-3862	Aetna Provider Service Center 888-632-3862		Frank Kyle, Sr. Market Compliance Consultant 801-933-3538 fkyle@aetna.com	Aetna c/o Compliance 10150 S. Centennial Pkwy. Suite 450 Sandy, UT 84070	1/1/2021	

List of Exhibits

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Exhibit K: NRS 439B.757 Participation Withdrawal Form



STATE OF NEVADA
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Consumer Health Assistance
 Bureau for Hospital Patients
 555 E. Washington Avenue, Suite 4800 | Las Vegas, Nevada 89101
 Phone: (702) 486-3587 | Toll Free (888) 333-1597
 Fax: (702) 486-3586 | E-mail: cha@govcha.nv.gov

FOR OFFICE USE ONLY
OCHA CASE # _____
RECEIVED BY: _____
DATE: _____

NRS 439B.757 Participation Withdrawal Form

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 this form to the Office for Consumer Health Assistance not less than 120 business days before the date on which the withdrawal is requested to become effective.

Third Party Name:	DBA (if applicable):
Third Party Type:	Requested Withdrawal Date:

Contact Information for Withdrawal Request

Contact Name:	Title:
Phone:	Mailing Address:
Email Address:	

Third Party or Designee (please print)

Title

Signature

Date

Email

Phone