STEVE SISOLAK
Governor

STATE OF NEVADA

TERRY REYNOLDS
Director

BARBARA D. RICHARDSON
Commissioner

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.nv.gov

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Health Carrier Provider Denial Letter

Nevada Revised Statute (NRS) 679B.124 requires the Commissioner of Insurance to develop, prescribe, and make available a form letter that a health carrier must use to notify a provider of health care[1] of the denial of the application to be included in the health carrier's network of providers. Health carriers should use the following guidance to comply with the reporting requirements under NRS 679B.124 section 2 and the changes made under Assembly Bill 45 (AB 45) of the 2021 Nevada Legislative Session[2].

1. **Health carriers must use the provider denial letter developed by the Commissioner of Insurance.** The form letter is available at http://doi.nv.gov/Insurers/Life-Health/Required-Industry-Reports/. The provider denial letter may be printed on the health carrier's letterhead but must be substantially the same as the form letter developed by the Commissioner. Adjustments may be made to accommodate provider groups, but must include the following information at minimum:
    a) The name of each individual provider and the corresponding National Provider Identifier (NPI)
    b) The address of the provider
    c) The specialty or specialties of each provider
    d) The specific reason(s) for the denial
    e) Contact information for appeals and/or the provider relations department
    f) The provider's appeal status, e.g., appeal available, appeals exhausted, etc.
2. **Health carriers must use the System for Electronic Rate and Form Filing (SERFF) for reporting provider denial letters to the Commissioner.**

[1] "Provider of health care" is defined in NRS 687B.660 (referring to NRS 695G.070).
[2] A copy of AB 45 of the 2021 Nevada Legislative Session can be found through the following link https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7298/Text

The provider denial reporting specified under Section 2 of NRS 679B.124 must be submitted to the Commissioner through SERFF under the Type of Insurance (TOI) – *Required Industry Reports - Insurers* and the Sub-TOI *Provider of Health Care Denial Letter*.

3. **Entities required to comply with the provisions in NRS 679B.124, section 2.**
   According to the statute, NRS 679B.124 applies to a "health carrier," which means

   > an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

   Therefore, any entity that meets the definition of "health carrier" and issues a denial to a provider relating to an application to be included in the entity's network is required to comply with NRS 679B.124.

4. **Frequency of Submission of Denial Letters.**
   The statute, as amended by AB 45, requires a health carrier to submit a copy of the denial letter at a frequency determined by the Commissioner. The Division is currently evaluating the appropriate frequency for submissions. During this evaluation period, submissions should be made no less than once a month. The submission should include a summary spreadsheet which includes all the information listed in section 1 of this Bulletin and the date the letter was sent to the provider for each provider denial letter submitted. In addition, a health carrier must submit to the Commissioner a copy of each form letter sent to a provider, which would include the initial denial letter and the final denial letter issued if the matter is appealed.

Questions concerning NRS 679B.124 or this Bulletin can be directed to the Life and Health staff in the Product Compliance section of the Division of Insurance, at (775) 687-0729 or productcompliance@doi.nv.gov.

BARBARA D. RICHARDSON
Commissioner of Insurance