

**[Nev. Rev. Stat. § 695G.162.]**

§ 695G.162. Required provision concerning coverage for services provided through telehealth: Coverage by Managed Care Organizations

1. A health care plan issued by a managed care organization for group coverage must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A managed care organization shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;

(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

3. A health care plan of a managed care organization must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require a managed care organization to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the managed care organization is not otherwise required by law to do so.

5. Evidence of coverage that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

6. As used in this section:

(a) “Distant site” has the meaning ascribed to it in NRS 629.515.

(b) “Originating site” has the meaning ascribed to it in NRS 629.515.

(c) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(d) “Telehealth” has the meaning ascribed to it in NRS 629.515.