STATE OF NEVADA

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DEPARTMENT OF BUSINESS AND INDUSTRY
OFFICE OF NEVADA BOARDS, COMMISSIONS AND COUNCILS STANDARDS

NEVADA STATE BOARD OF NURSING

AGENDA
NURSING PRACTICE ADVISORY COMMITTEE
Tuesday, November 3, 2026, 9:00 a.m.

THIS MEETING WILL BE HELD VIRTUALLY ONLY
To join the meeting via video, please click here:
https://teams.microsoft.com/meet/2703171586668360?p=eDuQQYwqnjEI9MhyAo

To join by meeting ID through Microsoft Teams:
Meeting ID: 270 317 158 666 836 0 **Passcode:** 9NB26uS3

To join by Telephone:
Audio Conference Number: +1 775-321-6111 **Phone Conference ID:** 649 180 275#

The Nursing Practice Advisory Committee meeting will commence at 9:00 a.m. on Tuesday, November 3, 2026.

- Items on the agenda mat be taken out of order.
- The committee may combine two or more agenda items for consideration.
- The committee may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
- For those who would like to listen to the meeting, please make sure to mute your phone once you join the meeting. Please only unmute when you are called upon to speak during the meeting.

The mission of the Nursing Practice Advisory Committee is to advise the Nevada State Board of Nursing on nursing practice issues to protect the public's health, safety and welfare through the effective regulation of nursing

Public Comment Procedure:

1. Public Comment will be taken at the beginning and at the end of the meeting; public comment may be made virtually or telephonically at 775-321-6111 and press Phone Conference ID 649 180 275# or via email at nsbnpubcom@nsbn.state.nv.us;
2. To provide Public Comment via video/teleconference, members of the public may join the meeting virtually or call the toll number above.
3. Public Comment may also be taken at other such times as requested so long as the request that Public Comment be taken will not interrupt ongoing committee business;
4. Those individuals wishing to present Public Comment are asked to state and spell their name prior to providing Public Comment.

5. Depending on the number of individuals wishing to address the committee, a reasonable time, place and manner limitation on the public comments may be set.
6. The Committee will not restrict comments bases upon viewpoint;
7. The Committee Chair reserves the right to limit Public Comment to three minutes;
8. No action may be taken upon a matter raised during Public Comment until the matter itself has been specifically included on an agenda as an item upon which action may be taken.

CALL TO ORDER

PUBLIC COMMENT:

For Possible Action

A. APPROVAL OF MEETING MINUTES: August 4, 2026, and September 29, 2026.

For Possible Action

B. OLD BUSINESS:

1. Review, discussion, and possible action regarding revisions to the Nevada State Board of Nursing Practice Decision titled "*Sexual Assault Nurse Examiner (SANE)*."

C. NEW BUSINESS:

1. Review and discussion of a presentation on national forensic nursing workforce and certification development relevant to the NSBN's (*SANE*) Nursing Practice Decision.

For Possible Action

2. Review, discussion and possible action regarding the committee's research to develop a Nevada State Board of Nursing Practice Decision addressing the scope of forensic nursing practice, training and competency requirements.

D. RECOMMENDATIONS FOR AGENDA ITEMS FOR THE NEXT MEETING ON: February 9, 2027.

PUBLIC COMMENT:

ADJOURNMENT

Anyone desiring additional information regarding the meeting, including information on how to obtain supporting board meeting material is invited to call Gabriela Hernandez-Aguilar, Management Assistant at (775) 687-7745. Supporting material for the public body is located at 6005 Plumas St, Suite 100, Reno, Nevada and 5820 S. Eastern Ave., Suite 200, Las Vegas, Nevada. Per NRS 241.020, persons/facilities desiring copies of the Board of Nursing agenda must submit their request in writing every six months. It is possible that an amended agenda, adding new items to the original agenda, will be published for any Board meeting. Amended notices will be posted in accordance with the Open Meeting Law; however, they will not be mailed to individuals on the Board's mailing list. The Board of Nursing complies with A.D.A requirements; persons requiring special equipment or considerations are requested to contact the Board's administrative office at least five days in advance of the meeting.

NOTICES POSTED AT THE FOLLING LOCATION

Nevada State Board of Nursing website www.nevadanursingboard.org

Nevada Public Notices website www.notice.nv.gov

Nevada State Board of Nursing offices:

6005 Plumas St, Suite 100, Reno, Nevada, 89519

5820 S. Eastern Ave., Suite 200, Las Vegas, Nevada, 89119

Posted: 10/27/2026

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NEVADA STATE BOARD OF NURSING

MEETING MINUTES
NURSE PRACTICE ADVISORY COMMITTEE

Tuesday, August 4, 2026

The Nursing Practice Advisory Committee Meeting was called to order by Sam McCord, RN BSN, Director of Investigations and Discipline at 9:00pm a.m. on August 4, 2026, via video and telephonic conferencing.

MEMBERS PRESENT

Lan Cabatingan, DNP, APRN, FNP-BC, PMGT-BC, CRRN, CGN-R CNEcl
Carrie Hintz, DNP, PhD, RN, CEN
Monica Green, MSN, RN, CCRN
Mike Stiller, BSN, RN, VA-BC
Jo Ann Kochelle, RN
Niculina C. Popa, RN
Pamela Adzima, DNP, MHA, RN
Megan McCrorey, MSN, RN, RHCEOC

MEMBERS ABSENT

Arlene Diaz, BSN, RN
Angela Shea, MLS RN

OTHERS PRESENT

Sam McCord, RN BSN, Director of Investigations and Discipline- *Chair*
Gabriela Hernandez-Aguilar, Management Assistant
Fred Olmstead, General Counsel
Pierron Tackes, General Counsel
Daen Evans, Guest

Call to Order: The meeting was called to order by Sam McCord at 2:00pm.

Public Comment: Sam welcomed Christina Popa from the Bureau of Healthcare Quality Compliance, who has replaced Jeanne Hesterlee after many years of service. Sam Also welcomed Megan McCror the newest committee member.

A. **Approval of Meeting Minutes:** Member Hintz made a motion to approve the meeting minutes from May 5, 2026, as written. Member Adzima seconded the motion. The motion

passed. Member Stiller made a motion to approve the meeting minutes from May 26, 2026, as written. Member Green seconded the motion. The motion passed.

B. Old Business: None.

C. New Business:

1. Sam McCord shared a few highlights from the July Board meeting. The Board approved RNs installing reversible agonists through an epidural catheter, as discussed at the last meeting. It passed without any changes. He also gave an update on the interstate compact, noting that Senator Titus has agreed to support the bill this session. Nevada remains one of the few states not yet part of the compact. He mentioned that the upcoming elections could change the makeup of the Legislature and impact support for the compact. Sam also shared the Board's newly elected officers, Elizabeth Trillips, President, Tyler Johnson, Vice President and Carla Dorian, Secretary.
2. Member Adzima made a motion to approve the revisions to the practice decision *The Role of the RN/LPN with Respirator/Ventilator* and refer the revisions to the LPN Committee for review and approval. Member Stiller seconded the motion.
3. The proposed 2027 meeting dates for the NPAC Advisory Committee were presented to the members. All members agreed to move the August meeting to the newly proposed date. The change was approved by all members. Member Stiller made the motion, and Member Adzima seconded the motion. Motion passed.
4. Members Hintz made a motion to establish a subcommittee to review and revise the practice decision and conduct additional research. Member Adzima seconded.

D. Recommendations for Agenda Items for Future Committee Meeting: None

Public Comment: Sam welcomed the Board's new counsel, Pierron Tackes.

Adjournment: The meeting adjourned at 10:00am.

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NEVADA STATE BOARD OF NURSING

MEETING MINUTES
NURSE PRACTICE ADVISORY SUBCOMMITTEE

Tuesday, September 29, 2026

The Nursing Practice Advisory Subcommittee Meeting was called to order by Sam McCord, RN BSN, Director of Investigations and Discipline at 9:00 a.m. on September 29, 2026, via video and telephonic conferencing.

MEMBERS PRESENT

Lan Cabatingan, DNP, APRN, FNP-BC, PMGT-BC, CRRN, CGN-R CNEcl
Pamela Adzima, DNP, MHA, RN
Carrie Hintz, DNP, PhD, RN, CEN

MEMBERS ABSENT

None

OTHERS PRESENT

Sam McCord, RN BSN, Director of Investigations and Discipline- *Chair*
Gabriela Hernandez-Aguilar - Management Assistant
Perrion Tackers - General Counsel
Mya Maples – Guest
Jessica Here – Guest
Sabrina Petrel - Guest

Call to Order: The meeting was called to order by S McCord at 9:04a.m.

Public Comment: None.

A. Approval of Meeting Minutes: None.

B. Old Business: Member Adzima made a motion to approve the changes to the Nevada State Board of Nursing Practice Decision titled "*Sexual Assault Nurse Examiner (SANE)*. Member Cabatingan seconded. Motioned passed.

C. New Business: None.

D. Recommendations for Agenda Items for Future Committee Meeting: None.

Public Comment: None.

Adjournment: The meeting adjourned at 9:49.

NEVADA STATE BOARD OF NURSING
Practice Decision
Forensic Nursing – Sexual Assault Nurse Examiner (SANE)

The NSBN finds it is within the scope of practice of a Registered Nurse to practice as a sexual assault nurse examiner (SANE) provided the following guidelines are followed:

1. Medical forensic examinations are performed by a SANE for individuals:
    a. Disclosing a history or concern of experiencing sexual assault.
    b. Suspected of experiencing sexual assault.
    c. Accused or suspected of committing sexual assault.

2. The registered nurse practicing as a SANE has completed appropriate additional education, including supervised clinical practice and demonstrated clinical competencies.
    a. The completed didactic educational program content shall meet, or exceed, the *Sexual Assault Nurse Examiner (SANE) Education Guidelines* published by the International Association of Forensic Nurses hosted by the Emergency Nurses.
    b. The completed didactic educational program shall be specific for the population receiving medical forensic examinations (i.e., adult/adolescent, pediatric, or both).
    c. A didactic education program for adult/adolescent medical forensic examinations shall include a minimum of forty (40) hours course work approved for continuing education credit or academic credit from an accredited educational institution.
    d. A didactic education program for pediatric/adolescent medical forensic examinations shall include a minimum of forty (40) hours course work approved for continuing education credit or academic credit from an accredited educational institution.
    e. A combined didactic education program for adults, adolescents, and pediatric medical forensic examinations shall include a minimum of sixty-four (64) hours course work approved for continuing education credit or academic credit from an accredited educational institution.
    f. Supervised clinical practice shall be provided by an appropriate provider with knowledge of providing medical forensic examinations and documented competency and experience providing such care.
    g. The registered nurse practicing as a SANE shall demonstrate clinical competence to perform all aspects of a medical forensic examination for the population served.

3. The registered nurse SANE shall maintain proficiency, as required by the current standards of nursing practice, to be verified in circumstances of gaining and maintaining employment as a SANE or upon request by the Board pursuant to NAC 632.071, 224, and 225.
4. ~~While completing the SANE education program, the registered nurse practices within the SANE scope of practice under the direct supervision of the education~~

DRAFT

~~program instructor, a physician, an advanced practice registered nurse, or another SANE with demonstrated and documented competence to provide forensic medical examinations.~~

5. The registered nurse SANE practices according to established protocols, agency policies, and procedures approved by a program director, program coordinator, or medical director who is a physician or advanced practice nurse with prescriptive authority.
    a. Established protocols shall include administering or dispensing medications for prophylaxis of sexually transmitted infections or pregnancy and referrals for additional care, follow-up, and other related services when appropriate.
    b. Protocols, agency policies, and procedures for forensic medical examinations shall be maintained at the practice site and be available for review by the Board.
6. The registered nurse SANE maintains accountability and responsibility for nursing care related to forensic medical examinations and follows the accepted standard of care, which would be provided by a reasonable and prudent nurse.
7. ~~The registered nurse SANE performs forensic medical exams in consultation with a physician or advanced practice registered nurse; never independently.~~

~~Additional requirements for pediatric forensic medical examinations involving individuals less than thirteen years of age:~~

1. ~~All pediatric forensic medical examinations shall undergo retrospective peer review by a physician or advanced practice registered nurse.~~
2. ~~All pediatric forensic medical examinations, which are deemed to have abnormal genital, ano-rectal, oral, or other abnormal physical findings, shall be referred to a recognized child sexual abuse expert who is a physician or advanced practice registered nurse for final diagnosis.~~
3. ~~Collection of samples for medical or forensic analysis from a pediatric patient shall only be performed by a registered nurse SANE who has ongoing, documented competence in providing pediatric forensic medical examinations that meets, or exceeds, the *Sexual Assault Nurse Examiner (SANE) Education Guidelines* published by the International Association of Forensics Nurses.~~

References

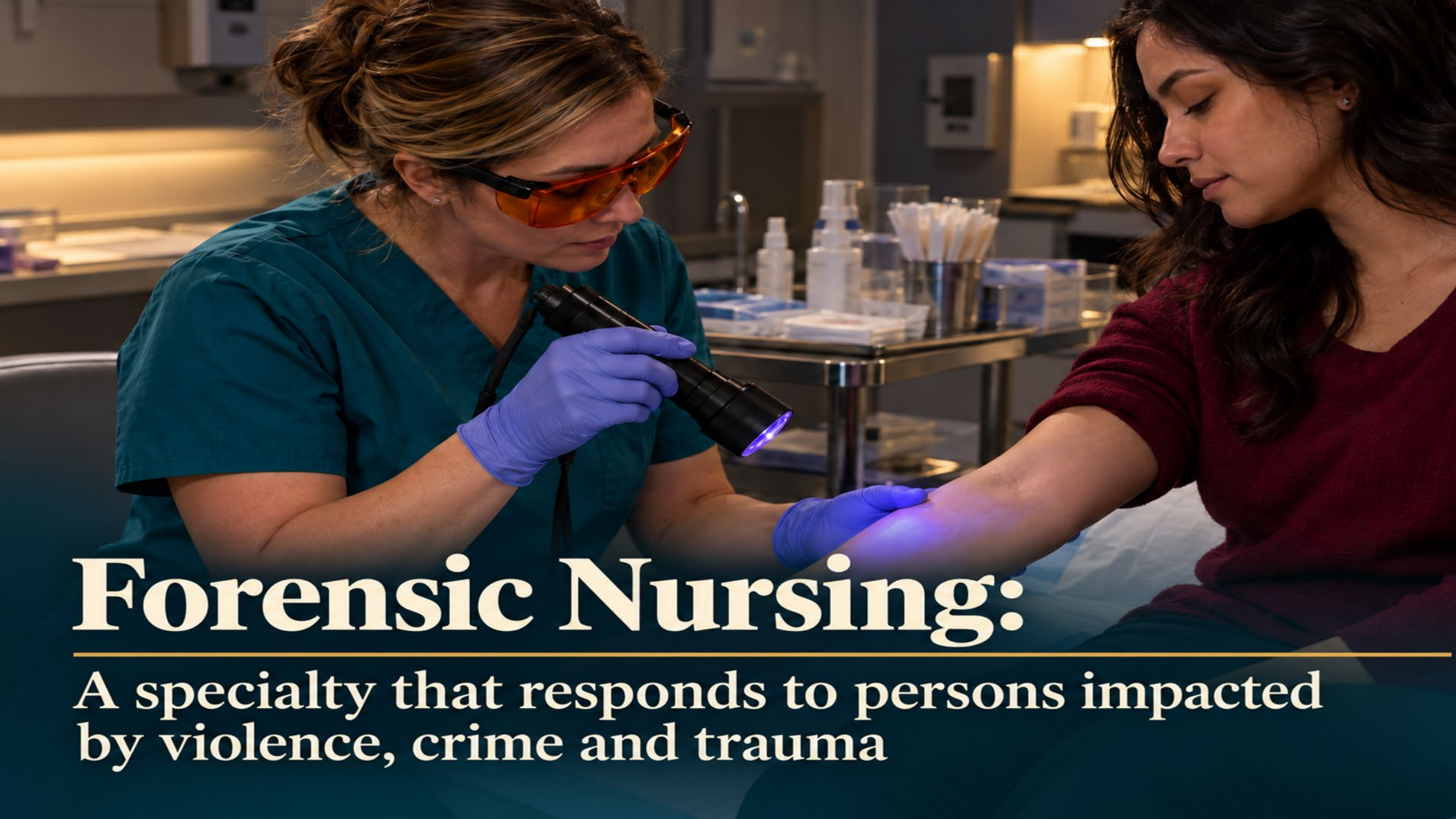
International Association of Forensic Nurses. (2017). *Forensic nursing scope and standards of practice* (2nd ed.). Silver Spring, MD: American Nurses Association.

International Association of Forensic Nurses. (2015). *Sexual assault nurse examiner (SANE) education guidelines*. Elkridge, MD: Author.

U.S. Department of Justices – Office of Violence Against Women. (2024). A national protocol for sexual assault medical forensic examinations (adults/adolescents) (3rd ed.). https://www.justice.gov/ovw/media/1367191/dl

Adopted by the Board: 4/1/04-Supersedes previous decision of 12/6/91-NPAC Reviewed:10/30/12-Adopted Revisions by Board: 11/7/12 – NPAC Reviewed: 02/06/2018-Board Approved: 03/23/2018 – NPAC Reviewed: pending.

DRAFT



Forensic Nursing:

A specialty that responds to persons impacted by violence, crime and trauma

FORENSIC NURSING EDUCATION

Forensic Nursing Workforce in Nevada

Forensic nurse examiners (FNEs)



3.4 million
Residents

42 million
Tourists annually

Nevada
Forensic Nurse
Alliance

Nevada Violence and Forensic Nursing, 2025



Crime rates per 100,000 residents

Aggravated assault	270.9
Rape	53.5
Homicide*	5.0

Firearm trauma: 457 registry cases
All intents; not a crime rate

Domestic violence and related cases

27,000+
Reported domestic violence cases statewide†

Battery	— 2025 total not verified
Stalking	— 2025 total not verified
Strangulation	— 2025 total not verified

*Murder and nonnegligent manslaughter. Crime rates use 3,282,188 residents.
†Rounded news-reported count; excludes unreported cases.
Sources: Nevada DPS TOPS; Census V2025; Nevada Trauma Registry 2025, Table 13; KLAS, Apr. 22, 2026.

Nevada Forensic Nurse Alliance

Access to Forensic Care in Nevada



17–22%

of sexual assault and domestic battery victims accessed forensic care annually

Reported access barriers

Forensic nursing workforce gaps

Limited availability of comprehensive forensic care

Nevada Forensic Nurse Alliance

Unequal Access and Long-Term Health Burden

FOR VICTIMS OF CRIME, VIOLENCE AND ABUSE

Unequal access

Forensic nursing workforce gaps

Long travel distances

Barriers to timely, comprehensive care

Can delay care

Unmet health needs

Untreated injuries and persistent pain

PTSD, depression and anxiety

Substance use disorders

Increased risk of chronic disease

Can increase care needs

Greater system demands

Emergency and repeat visits

Ongoing medical treatment

Behavioral health and crisis services

More complex, long-term care

Timely, coordinated forensic care connects survivors with treatment and ongoing support.

Sources: CDC, Violence Prevention (2025); WHO, Violence Against Women (2026); NCEDSV, SANE Report (2024).

Nevada Forensic Nurse Alliance

Unmet Trauma Needs and Risk of Future Violence

VICTIMIZATION DOES NOT DETERMINE A SURVIVOR'S FUTURE BEHAVIOR

Violence and unmet needs

Unaddressed injuries or distress

Safety and support needs unmet

May compound risk

Risks can accumulate

Ongoing exposure to violence

Limited support and coping resources

Not inevitable

Possible later outcomes

Repeat victimization

Violence perpetration by some survivors

Early care can interrupt this pathway

Trauma-informed forensic care and safety planning
Behavioral health treatment, stable support and follow-up

Risk factors are not predictions. Responsibility for abusive behavior rests with the person who commits it.

Sources: CDC, ACEs Risk and Protective Factors; CDC, Intimate Partner Violence Risk Factors; CDC, Connecting the Dots.

Nevada Forensic Nurse Alliance

Evidence Gaps and the Risk of Repeat Offending

TIMELY INVESTIGATION CAN SUPPORT ACCOUNTABILITY AND HELP PREVENT FURTHER HARM

Missed opportunities

No timely investigation

Evidence not collected or preserved

Injuries and accounts not documented

Can weaken investigations

Limits on accountability

Fewer investigative leads

Missed links between related crimes

Cases may be harder to prove

May allow continued harm

Risk of further harm

Offenders may remain unidentified

Patterns of abuse may go undetected

Opportunities for repeat offending

A coordinated response can interrupt this pathway

Forensic care and documentation, with informed consent
Evidence preservation, appropriate testing and investigative follow-through

Repeat offending is not inevitable. Absence of forensic evidence does not mean a crime did not occur.
Responsibility for offending rests with the perpetrator, not the survivor.

Sources: NIJ, Five Things About Deterrence; BJA, Sexual Assault Kit Initiative; NIJ, National Best Practices for Sexual Assault Kits.

Nevada Forensic Nurse Alliance

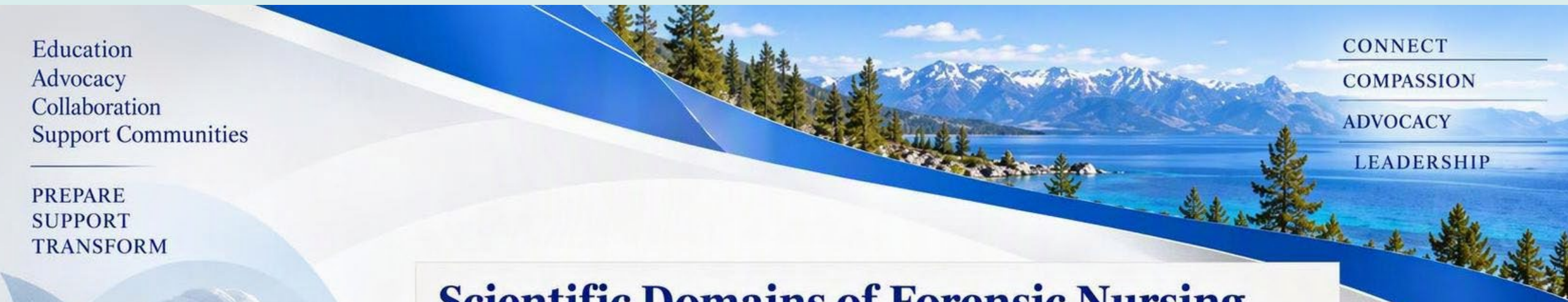
Nevada
FORENSIC NURSE
Alliance



Education
Advocacy
Collaboration
Support Communities

PREPARE
SUPPORT
TRANSFORM

CONNECT
COMPASSION
ADVOCACY
LEADERSHIP



Forensic Nights Are Never Isolated

Scientific Domains of Forensic Nursing

NURSING

- Clinical assessment and care
- Trauma-informed support
- Referral and follow-up

FORENSIC

- Injury and evidence assessment
- Evidence collection and preservation
- Objective documentation

LEGAL

- Consent and patient rights
- Reporting duties and confidentiality
- Impartial testimony

Patient care, scientific evidence and legal principles guide forensic nursing

Nevada Forensic Nurses

NevadaForensicNurses.org

Role & Responsibilities

1. Medical forensic examinations
2. Evidence collection and management
3. Documentation of examination findings using a Forensic Electronic Medical Record
4. Photodocumentation that meets evidentiary requirements
5. Correlation of findings with history and other medical diagnostics
6. Report writing and testifying at trial



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Forensic Nurse
Alliance

FORENSIC NURSING EDUCATION

Common Cases in Forensic Nursing

Care across the lifespan, from childhood through older adulthood

01 Sexual violence
02 Human trafficking
03 All forms of physical abuse and assault
04 Perforating and penetrating wounds
05 Strangulation
06 Child abuse and exploitation
07 Elder abuse and maltreatment



Nevada Forensic Nurse Alliance

FORENSIC NURSING EDUCATION

Education & Preparation for the Role

1 year of nursing experience

FOUNDATIONAL COURSES

01 Sexual Violence Forensic Nursing

02 Strangulation Examination and Response

03 Pediatric Trauma Related to Violence and Crimes

04 Forensic Photography

Forensic Nursing Master's Programs

Available at several universities

Nevada Forensic Nurse Alliance

FORENSIC NURSING EDUCATION

Certifications in Forensic Nursing

ENTRY PATHWAY CERTIFICATIONS

01 Forensic Nurse Generalist

02 Advanced Forensic Nurse

MICROCERTIFICATIONS

01 Sexual Violence Forensic Nursing

02 Interpersonal Violence and Strangulation

03 Human Trafficking

Nevada Forensic Nurse Alliance

Professional Growth and Development

PROFESSIONAL ORGANIZATION MEMBERSHIP

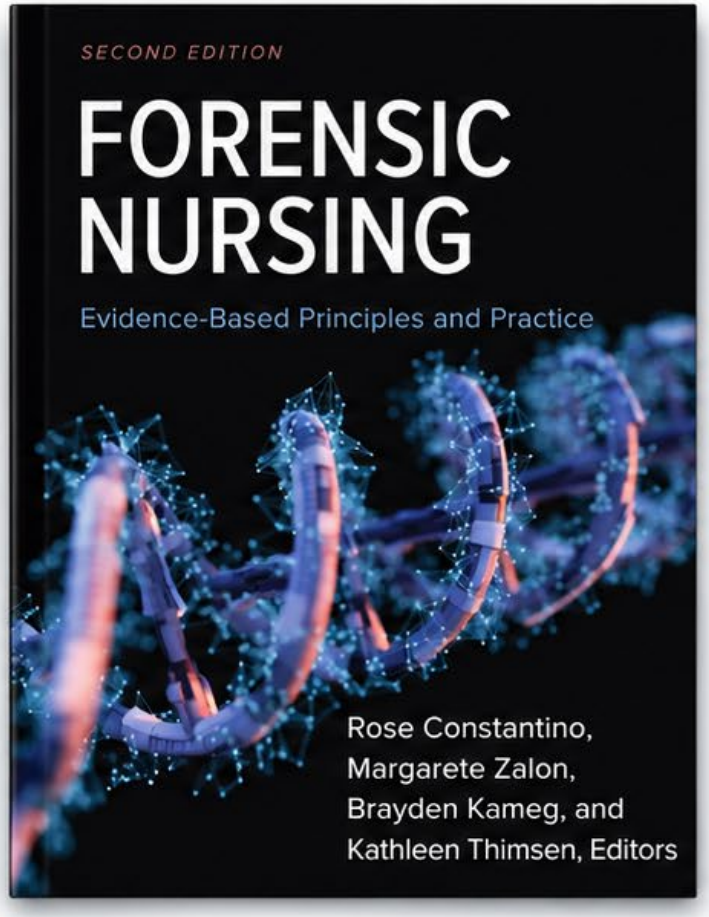
01 Academy of Forensic Nursing

02 American Academy of Forensic Sciences

03 Forensic Nursing Certification Board

04 Nevada Forensic Nurse Alliance

FORENSIC NURSING EDUCATION



Forensic Nursing

Evidence-Based Principles and Practice

Second Edition • Cognella Academic Publishing

Clinical care + forensic science

Connects clinical nursing skills with evidence-based forensic principles.

Examination + evidence

Addresses evidence collection, examination and injury identification.

Care across forms of violence

Includes sexual assault, intimate partner violence, child maltreatment, trafficking and strangulation.

Trauma-informed learning

Uses case studies and learning exercises to connect knowledge with practice.

Source: Cognella publisher catalog • ISBN 9798823302739 • Publisher copyright ©2027

Nevada Forensic Nurse Alliance

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Nevada Forensic Nurse Alliance

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Nevada Forensic Nurse Alliance

PROPOSAL FOR THE NEVADA STATE BOARD OF NURSING

Recognize the Full Forensic Nursing Role

Expand the SANE Practice Decision to address medical-forensic care for all forms of violence, crime and abuse.

Broader patients and services

Across the lifespan, genders and abilities

Sexual violence, domestic violence, strangulation, trafficking, assault, and child or elder abuse

Assessment, care, documentation, evidence collection with consent, and coordinated follow-up

Alignment with national guidance

IOM: Practice to the full extent of education and training.

Carnegie: Strengthen clinical preparation, judgment and professional formation.

Academy of Forensic Nursing (AFN): Evidence-based education for full-scope forensic nursing.

DOJ: Medical-forensic profocols, including intimate partner violence.

Practice matched to education, demonstrated competence and licensure

Proposed for Board consideration. Nevada law and current Board requirements remain in effect.

Sources: NSBN SANE Decision (2018); IOM (2011); Carnegie (2010); AFN, Evidence-Based Forensic Nursing Education (2020); DOJ IPV Protocol (2023).

Nevada Forensic Nurse Alliance

NEVADA COMPREHENSIVE FORENSIC EXAMINATION ACT

Legislative Concept, Working Statutory Language, Policy Crosswalk, and Implementation Framework

I. Legislative Concept

Problem. Nevada currently provides an express direct-payment mechanism for two categories of specialized medical forensic examinations: sexual-assault forensic medical examinations under NRS 217.300 and strangulation forensic medical examinations under NRS 217.405. Those examinations have a defined pathway for direct reimbursement to the forensic provider or program through the Fund for the Compensation of Victims of Crime. Comparable direct forensic-provider reimbursement is not expressly available for many other categories of criminal violence, abuse, neglect or exploitation.

This creates a practical access gap, not merely a medical-billing issue. Medical forensic programs must be able to sustain the specialized clinicians, training, documentation systems, photography and evidence equipment, consultation resources, quality processes, on-call capacity and administrative infrastructure necessary to provide these examinations. When no reliable reimbursement mechanism exists for a category of medical forensic examination, a forensic provider or program may be unable to develop, staff or offer that service even when a patient has a legitimate medical and forensic need.

The result is that access to specialized medical forensic care may depend in part on the crime category associated with the patient's presentation rather than on the patient's actual clinical and forensic needs. Nevada's existing sexual-assault and strangulation reimbursement pathways demonstrate that the State recognizes the value of specialized forensic examinations. The remaining policy gap is to extend a comparable direct reimbursement pathway so that victims of other qualifying crimes can obtain access when a medical forensic examination is medically or forensically indicated.

Proposed solution. Create an umbrella statutory category of "medical forensic examination" and extend Nevada's direct forensic-provider reimbursement pathway across qualifying crime types. Eligibility should follow the patient's medical and forensic needs and the specialized services actually provided, rather than being limited to sexual assault or strangulation as offense categories. The framework would include, without limitation, sexual violence, strangulation or suffocation, domestic or intimate partner violence, physical assault, child abuse or neglect, abuse or exploitation of an older or vulnerable person, human trafficking, and other criminal violence for which specialized medical forensic services are indicated.

Payment mechanism.

Use Nevada's existing Fund for the Compensation of Victims of Crime and direct-provider payment infrastructure as the state payment mechanism for qualifying medical forensic examinations. Permit lawful use of federal VOCA Victim Compensation funds and other available state or federal sources. The forensic examination payment is directed to the qualified forensic provider or program for the specialized forensic service; it is distinct from ordinary medical billing for emergency treatment, hospitalization, imaging, surgery or other general medical care. If the Fund is insufficient, establish a statewide state-funded backstop rather than shifting the remaining obligation to the county in which the offense occurred.

Federal policy context. The proposal is informed by, but is independent from, the federal Ensuring Forensic Care for All Victims Act (EFCA), S. 2655 (117th Congress). EFCA is cited as a policy analogue supporting broader medical forensic capacity; the Nevada proposal has its own title, structure, payment mechanism, and statutory purpose.

II. Recommended Legislative Objectives

- Create one statewide payment framework for qualifying medical forensic examinations across crime types.
- Create a reliable direct reimbursement pathway for qualified forensic providers and programs so that examination services can be developed, staffed, maintained and offered for victims of qualifying crimes beyond sexual assault and strangulation.
- Ensure the patient is not billed or balance billed for reimbursable medical forensic examination services.
- Base eligibility on a medically or forensically indicated need for specialized examination services, not on the final criminal charge.
- Preserve existing sexual-assault and strangulation rights while incorporating those examinations into a broader payment framework.
- Expressly distinguish reimbursable medical forensic examination services from ordinary medical diagnosis and treatment.
- Authorize differentiated reimbursement rates based on examination type, complexity, consultation needs, and follow-up services.
- Authorize telehealth-supported forensic consultation when clinically appropriate and consistent with scope-of-practice requirements.
- Establish provider and program competency standards by regulation without locking the statute to one credential or professional title.
- Recognize that provider and program capability is examination-category-specific and patient-population-specific; no provider or program is required or presumed to offer every medical forensic examination covered by the Act.
- Ensure access does not depend on law-enforcement reporting, arrest, charging, prosecution, conviction, visible injury, substantiation by another agency, or evidence-kit collection.
- Use a statewide funding backstop to reduce geographic disparities in access and payment.
- Require limited claims data and aggregate public reporting while protecting the forensic record, photographs, and patient-identifying information.

III. Current Nevada Law and Proposed Change

Current Nevada law	Current limitation	Proposed change	Policy effect
NRS 217.160(1)(f): compensation may be paid directly to a medical provider for an examination under NRS 217.300 or 217.405.	Direct provider payment is expressly tied to two named examination categories.	Authorize direct payment for any qualifying medical forensic examination under the new umbrella section.	Uses existing compensation infrastructure rather than creating a new payer.
NRS 217.300: sexual-assault forensic medical examinations; Fund payment; county backstop; police report not required.	The examination definition is tied to sexual assault and framed primarily around evidence collection.	Preserve sexual-assault-specific rights while cross-referencing the broader medical forensic framework.	Keeps existing protections and modernizes the concept of medical forensic care.

NEVADA COMPREHENSIVE FORENSIC EXAMINATION ACT

Current Nevada law	Current limitation	Proposed change	Policy effect
NRS 217.405: strangulation forensic medical examinations in the domestic-violence context; Fund payment; county backstop.	The payment pathway is offense-context specific and does not cover every strangulation/suffocation or other violent-crime presentation.	Preserve existing protections and incorporate the examination into the broader payment framework.	Reduces offense-label gaps while maintaining current rights.
NRS 178A.190: sexual-assault survivors are not required to pay forensic examination expenses under NRS 217.300.	Cost protection is specific to sexual assault.	Add a broader no-billing provision without diminishing Chapter 178A rights.	Creates cost protection across qualifying crime types.
Nevada Victims of Crime Program reimburses qualifying crime-related medical expenses.	Ordinary victim-compensation claims are not designed as a real-time payment pathway for specialized forensic examinations.	Permit direct provider claims for qualifying examinations without requiring the patient first to complete an ordinary compensation claim.	Reduces delay and prevents the patient from becoming the financial intermediary.
Existing statutes use county responsibility when the Fund is insufficient.	County backstops can create geographic fiscal variation and undermine a statewide access policy.	Replace the county backstop for qualifying examinations with a statewide appropriation/reserve mechanism.	Aligns statewide access with statewide fiscal responsibility.

IV. Proposed Bill Language — Working Draft for LCB

AN ACT relating to victims of crime; establishing the Nevada Comprehensive Forensic Examination Act; providing for access to and payment for qualifying medical forensic examinations following criminal violence, abuse, neglect or exploitation; prohibiting certain costs from being charged to a patient; requiring payment of qualifying examinations from the Fund for the Compensation of Victims of Crime; establishing a statewide funding backstop; requiring reimbursement rates, provider standards, claims procedures and aggregate reporting; preserving existing rights and reporting duties; revising related provisions governing compensation; and providing other matters properly relating thereto.

Section 1. Short title.

This act may be cited as the "Nevada Comprehensive Forensic Examination Act."

Section 2. Legislative findings and intent.

1. The medical and forensic needs of a person affected by criminal violence, abuse, neglect or exploitation are not determined solely by the statutory classification of the suspected offense.
2. Persons affected by sexual violence, strangulation or suffocation, domestic or dating violence, physical assault, child abuse or neglect, abuse or exploitation of an older or vulnerable person, human trafficking, and other criminal violence may require specialized medical forensic evaluation, injury documentation, forensic photography, evidence-related services, treatment coordination and follow-up.
3. Nevada has already established direct payment mechanisms for sexual-assault forensic medical examinations and strangulation forensic medical examinations through the Fund for the Compensation of Victims of Crime, thereby recognizing those examinations as specialized forensic health care services warranting direct provider reimbursement.
4. The absence of a reliable direct reimbursement pathway for other categories of medical forensic examination may limit the ability of qualified providers and programs to develop, staff, maintain or offer those services, even when victims have comparable medical and forensic needs.
5. Statewide access to specialized medical forensic services should be based on medical and forensic need rather than on whether the suspected conduct falls within one of the limited offense categories for which a direct forensic-provider payment pathway already exists.
6. Comparable medical forensic services should be available and reimbursable when medically or forensically indicated regardless of the offense ultimately alleged, charged, substantiated or prosecuted.
7. A medical forensic examination is a health care service with forensic functions and is not limited to evidence-kit collection.
8. It is the intent of the Legislature to establish a consistent statewide mechanism for access to and direct reimbursement of qualifying medical forensic examinations so that qualified providers and programs can make those services available across crime types without imposing the reimbursable cost of the forensic examination on the patient.

Section 3. Definitions.

1. "Medical forensic examination" means a specialized examination, evaluation or consultation conducted by a qualified medical provider for a person who has experienced or is reasonably suspected of having experienced criminal violence, abuse, neglect or exploitation, when the service is medically or forensically indicated because specialized assessment, documentation, evidence-related services, injury interpretation, safety planning, treatment coordination or forensic follow-up is reasonably necessary.

2. A medical forensic examination may include, without limitation:
   (a) assessment of the patient's immediate health care and safety needs;
   (b) a medical forensic history relevant to the reported or suspected event;
   (c) a focused or comprehensive physical examination within the provider's scope of practice;
   (d) identification, description and documentation of physical findings or the absence of findings;
   (e) body diagrams, forensic photography, alternate light source examination when appropriate, or other accepted documentation methods;
   (f) collection, identification, preservation, packaging or transfer of biological, trace, toxicological or other evidence when indicated;
   (g) medications, prophylaxis, point-of-care testing, limited laboratory services, discharge instructions and referrals that the administering agency designates as ordinarily bundled within a qualifying examination rate;
   (h) telehealth or other real-time specialist medical forensic consultation when clinically appropriate;
   (i) forensic follow-up examination or reassessment when reasonably related to the initial medical forensic examination; and
   (j) other services established by regulation that are reasonably necessary to accomplish the medical or forensic purposes of the examination.
3. "Ordinary medical care" means diagnosis or treatment that is not part of the specialized medical forensic service and includes, unless specifically incorporated into a reimbursement category by regulation, emergency stabilization, inpatient hospitalization, surgery, advanced diagnostic imaging, specialist medical management, treatment of unrelated conditions, and other general medical services customarily billed through ordinary health care payment mechanisms.
4. "Qualified medical provider" means a provider of health care acting within the provider's lawful scope of practice who possesses the education, training, competency, documentation and qualifications appropriate to the applicable category of medical forensic examination and patient population, consistent with applicable law and evidence-based or evidence-informed medical and medical forensic professional standards. Qualification must not depend on a single professional credential when competency may lawfully be demonstrated through another recognized pathway.
5. "Qualifying patient" means a person of any age who has experienced or is reasonably suspected by a qualified medical provider of having experienced criminal violence, abuse, neglect or exploitation and for whom a medical forensic examination is medically or forensically indicated.
6. "Administering agency" means the state agency, division, office or program designated by law to administer the Fund for the Compensation of Victims of Crime and the reimbursement, claims, reporting and other administrative provisions of this Act. Administrative authority under this Act does not independently create or expand a provider's clinical scope of practice or supersede otherwise applicable professional standards.

Section 4. Covered crime and maltreatment contexts.

A qualifying medical forensic examination may arise from, without limitation:

1. sexual assault, sexual abuse or other sexual violence;
2. strangulation or suffocation;
3. domestic violence or dating violence;
4. physical assault or other interpersonal violence;
5. child abuse or neglect;

6. abuse, neglect, isolation, abandonment or exploitation of an older person or vulnerable person;
7. human trafficking;
8. an assault involving a weapon or other mechanism capable of producing bodily injury; or
9. any other suspected criminal act for which specialized medical forensic assessment, documentation, consultation, evidence-related services or follow-up is medically or forensically indicated.
10. A qualifying medical forensic examination is not limited by the initial referral reason, presenting complaint, offense label or mechanism first reported. If, during the medical forensic history or examination, the patient discloses or the provider identifies an additional mechanism of violence that requires specialized medical forensic assessment, the qualified medical provider may expand the examination to address the additional medical and forensic needs.
11. A single medical forensic encounter may include assessment of more than one mechanism of violence, including, without limitation, physical assault accompanied by strangulation or suffocation, sexual violence, head trauma, use of a weapon or other mechanisms requiring specialized assessment, documentation, consultation, evidence-related services or follow-up.

Section 5. Payment of qualifying medical forensic examinations.

1. The reimbursable cost of a qualifying medical forensic examination must not be charged directly to the qualifying patient, the patient's parent or guardian, or a person responsible for the care of the patient.
2. The reimbursable cost of a qualifying medical forensic examination must be paid directly to the medical provider or eligible medical forensic program from the Fund for the Compensation of Victims of Crime, subject to the reimbursement rate established by the administering agency.
3. The purpose of direct payment under this section is to establish a viable reimbursement pathway for the qualified forensic provider or program that performs the specialized medical forensic service, thereby supporting the availability of qualifying examinations across covered crime and maltreatment contexts.
4. If money in the Fund is insufficient to satisfy the obligations imposed by this section, the remaining obligation must be satisfied through a statewide appropriation, reserve or other state funding mechanism established by law. The remaining obligation should not be shifted to the county in which the offense occurred solely because of geographic jurisdiction.
5. Money received through the federal Victims of Crime Act Victim Compensation Program and any other federal, state, local, private or grant funding legally available for the purpose may be used to satisfy obligations under this section.
6. Payment under this section constitutes payment in full for services included within the applicable reimbursement category, and the provider or program shall not balance bill the qualifying patient for the difference between the provider's usual charge and the established reimbursement amount.
7. A qualifying patient must not be required to submit the reimbursable medical forensic examination charge to private insurance, Medicaid, Medicare or another third-party payer as a prerequisite to payment under this section, except to the extent required by federal law as a condition of using a particular federal funding source.
8. This section does not prohibit a provider from billing ordinary medical care, as defined in this act, to the payer otherwise responsible for that care. A provider may not obtain duplicate payment for the same service from the Fund and another payer.

Section 6. Medical forensic examination distinguished from ordinary medical care.

1. The administering agency shall identify, by regulation or published reimbursement schedule, the services bundled within each category of qualifying medical forensic examination.

2. A specialized forensic history, forensic examination, injury documentation, forensic photography, evidence-related services, qualifying consultation, forensic discharge planning and designated follow-up services may be included in the medical forensic reimbursement rate.
3. Ordinary medical care remains separately billable through the patient's usual health care payment mechanism or another legally responsible payer unless the administering agency expressly includes a particular service within a medical forensic reimbursement category.
4. Nothing in this act shifts to the Fund financial responsibility for general medical treatment that would otherwise be payable by another legally responsible payer, except as expressly provided by statute or regulation.

Section 7. Access shall not depend upon criminal-justice or evidentiary outcomes.

Eligibility for a qualifying medical forensic examination or payment under this act must not be conditioned upon:

1. filing a report with a law enforcement agency;
2. identification or arrest of a suspected offender;
3. filing or prosecution of criminal charges;
4. participation by the patient in a criminal investigation or prosecution;
5. a determination of probable cause, substantiation by another agency, or a particular charging decision;
6. a conviction or other adjudication;
7. the presence of visible physical injury;
8. collection of a sexual assault kit, evidence kit or any other forensic specimen;
9. submission of collected evidence for laboratory analysis;
10. the patient's ability or willingness to provide a complete history;
11. establishment of the precise location or jurisdiction of the suspected offense before the examination; or
12. confirmation that the suspected conduct ultimately constitutes a particular offense.

Section 8. Evidence collection is not required.

1. A medical forensic examination may qualify for reimbursement whether or not forensic evidence is collected, an evidence kit is used, evidence is transferred to law enforcement, or evidence is ultimately submitted for laboratory analysis.
2. The absence of evidence collection does not, by itself, establish that a medical forensic examination lacked a medical or forensic indication.

Section 9. Children, older persons and vulnerable persons.

1. Eligibility for payment must not depend on prior referral, authorization or substantiation by law enforcement, a child welfare agency, adult protective services, a multidisciplinary team, a child advocacy center or another governmental entity.
2. A qualified medical provider may determine that an examination is indicated based on the patient's history, presentation, age, developmental status, reported or suspected mechanism, health care needs, safety concerns and forensic considerations.
3. Nothing in this act alters mandatory reporting, consent, assent, guardianship, protective custody or other duties imposed by Nevada law.

Section 10. Telehealth and medical forensic consultation.

1. The administering agency may reimburse real-time telehealth or other remote medical forensic consultation when used to support a qualifying medical forensic examination and when the service complies with Nevada scope-of-practice, telehealth, privacy and documentation requirements.
2. A remote consultant may assist with history formulation, examination technique, injury interpretation, photography, evidence considerations, treatment recommendations, disposition and follow-up.
3. Telehealth consultation does not authorize a remote provider to perform a service that, under applicable law or clinical standards, requires an in-person examination by an onsite provider.
4. Retrospective expert review for litigation, testimony preparation or other legal consulting is not a qualifying medical forensic examination service solely by virtue of this section.

Section 11. Provider and program standards.

1. Eligibility for reimbursement under this Act must be limited to providers and programs that meet reasonable, examination-category-specific and patient-population-specific qualifications consistent with lawful scope of practice, demonstrated competency, applicable law, and evidence-based or evidence-informed medical and medical forensic professional standards.
2. Relevant professional and program qualifications may address education, supervised clinical preparation, competency assessment, scope of practice, documentation, photography, evidence handling, quality review, continuing education, privacy, referral pathways and maintenance of competency. Administrative requirements used to verify eligibility for reimbursement must not create or expand clinical scope of practice or supersede otherwise applicable professional standards.
3. Standards should be proportionate to the examination category and should permit multiple lawful competency pathways, including physician, advanced practice registered nurse, registered nurse and other provider pathways when consistent with Nevada law and the services performed.

Section 12. Program scope, patient population and clinical capability.

1. Nothing in this Act shall be construed to require or authorize every qualified medical provider, medical forensic program, hospital, clinic or other facility to perform every category of medical forensic examination recognized under this Act.

2. A provider or program may perform and receive reimbursement only for medical forensic services that are: (a) within the lawful scope of practice of the provider; (b) within the demonstrated education, training and competency of the provider or program; (c) appropriate for the age, developmental status and clinical characteristics of the patient population for which the provider or program is qualified; (d) supported by the equipment, supplies, policies, procedures, consultation resources, referral pathways and clinical infrastructure reasonably necessary to provide the service safely and appropriately; and (e) consistent with applicable evidence-based or evidence-informed standards of medical and medical forensic practice.

3. Qualification to provide one category of medical forensic examination does not, by itself, establish qualification to provide another category of examination or to evaluate a different patient population.

4. The administering agency may establish administrative criteria for recognizing providers and programs for reimbursement by authorized examination category and patient population. Such administrative recognition must be based on the provider or program demonstrating qualifications consistent with applicable law and professional standards and does not create independent clinical authority. Recognition may distinguish, without limitation, among adult and adolescent patients; prepubertal children; older or vulnerable persons; acute and nonacute examinations; sexual assault or

sexual abuse examinations; strangulation or suffocation examinations; physical assault and interpersonal violence examinations; child maltreatment examinations; human trafficking examinations; follow-up examinations; and medical forensic consultation services.

5. A provider or program shall maintain a process for consultation, transfer or referral when a patient's medical or forensic needs exceed the provider's lawful scope of practice, demonstrated competency, authorized examination category, approved patient population or available clinical resources.

6. Nothing in this Act requires a provider or program to perform an examination or examination component that would be inconsistent with the provider's lawful scope of practice, professional competency, applicable standards of care, evidence-based or evidence-informed practice, or the program's established clinical capabilities.

7. A provider or program may receive reimbursement only for examination categories and services for which it satisfies the applicable qualification criteria for reimbursement and the clinical requirements of this Act; referral, transfer or consultation for services outside that capability is consistent with appropriate medical forensic practice and must not be treated as failure to complete a qualifying examination.

Section 13. Patient consent, autonomy, timing and scope of examination.

1. A medical forensic examination is a health care service requiring informed consent in accordance with applicable Nevada law. Consent should be obtained for the examination and, when applicable, for distinct components including photography, anogenital examination, evidence collection, toxicology testing, medications, release of information and other procedures.

2. A qualifying patient may consent to some components of a medical forensic examination and decline or withdraw consent to other components. Declining or withdrawing consent to a component must not, by itself, make an otherwise qualifying examination ineligible for reimbursement.

3. A qualifying medical forensic examination need not include every potentially available examination component. Reimbursement must not be denied solely because: (a) the patient declines a component; (b) the provider determines a component is not medically or forensically indicated; (c) the encounter is appropriately focused or limited; (d) the examination is interrupted for clinical, safety or patient-centered reasons; or (e) the patient is transferred or referred for services outside the provider or program's authorized capability.

4. Eligibility for a medical forensic examination must not be denied solely because a specified number of hours or days has elapsed since the reported or suspected event. The timing and components of an examination must be determined by the patient's medical and forensic needs, recognizing that evidence-collection decisions may be subject to separate time-sensitive considerations.

5. Nothing in this section alters Nevada law governing consent, assent, parental or guardian authority, decision-making capacity, emergency care, protective custody or mandatory reporting.

6. A medical forensic history is obtained for health care and medical forensic assessment. It is not a substitute for a law-enforcement interrogation, child forensic interview or other investigative interview, although information documented during the health care encounter may have evidentiary significance as otherwise provided by law.

Section 14. Reimbursement categories and rates.

1. The administering agency shall annually review and establish reasonable maximum reimbursement rates for qualifying medical forensic examinations.
2. The administering agency may establish separate rates or bundled payment categories, including, without limitation:

(a) acute sexual assault or sexual abuse examination;

(b) nonacute sexual abuse examination;

(c) strangulation or suffocation examination;

(d) physical assault or interpersonal violence examination;

(e) child maltreatment medical forensic examination;

(f) older-person or vulnerable-person maltreatment examination;

(g) human trafficking medical forensic examination;

(h) forensic follow-up examination; and

(i) telehealth or specialist medical forensic consultation.

3. In establishing rates, the administering agency shall consider qualified provider time; complexity; documentation; photography; evidence collection and transfer; supplies and equipment; medications and testing ordinarily bundled in the examination; consultation; follow-up; geographic access; on-call capacity; quality requirements; and reasonable administrative costs necessary to maintain medical forensic examination services.
4. Before establishing the initial reimbursement schedule for examination categories newly covered by this Act, the administering agency shall conduct or obtain a cost analysis sufficient to determine the reasonable cost of providing each category of medical forensic examination. The analysis must consider provider time; complexity; post-examination documentation; forensic photography; evidence-related services; supplies and equipment; medications and testing included within the forensic service; consultation; follow-up; quality assurance; training and competency requirements; on-call and readiness costs; administrative expenses; and geographic factors affecting access to care.
5. Reimbursement methodology must account for the reasonable cost of maintaining and delivering qualified medical forensic services and must not be based solely on the amount of time during which a provider is physically examining the patient.
6. The administering agency may establish complexity levels, extended-examination modifiers, multi-mechanism modifiers, rural or frontier access adjustments, separate consultation rates, separate follow-up rates, and professional or program/facility components when necessary to reasonably reimburse the services required for a qualifying medical forensic examination.
7. In developing the initial rate schedule and material revisions to the rate methodology, the administering agency should obtain input from medical forensic clinicians and programs, hospitals and emergency medical facilities, community-based medical forensic programs, pediatric and vulnerable-adult medical providers, rural and frontier providers, the Victims of Crime Program, Nevada Medicaid, victim-service organizations and other affected stakeholders.
8. A provider or program that appropriately refers or transfers a patient for medical care or forensic services outside its authorized scope, patient population or clinical capability remains eligible for reimbursement for qualifying medical forensic services actually provided. The receiving provider or facility may seek reimbursement only for additional qualifying services actually performed and may not duplicate bill a forensic component already reimbursed.
9. The reimbursement methodology must not create a financial incentive for a provider or program to exceed its competency or clinical capability, or a financial penalty for appropriate consultation, referral or transfer.

Section 15. Claims and documentation.

1. The administering agency shall establish a uniform direct-provider claims process that minimizes delay and does not require the qualifying patient to complete the ordinary victim-compensation application process solely for payment of the qualifying examination.

2. The claim may require only information reasonably necessary to establish eligibility and process payment, including the examination category, date and location of service, provider or program identifier, services performed, applicable reimbursement code, and an attestation that statutory criteria were met.
3. A provider must not be required to submit the complete medical forensic record, forensic photographs, detailed narrative history or collected evidence as a routine condition of payment. The administering agency may request additional information when reasonably necessary to investigate a specific claim, subject to applicable privacy and evidentiary protections.
4. Claims procedures must permit payment when the location or jurisdiction of the suspected offense is unknown, disputed, outside Nevada, tribal or federal, when Nevada is the place where the qualifying examination is provided and no other payer is legally responsible for the forensic examination charge.
5. Nevada residency must not be a prerequisite to payment when a qualifying medical forensic examination is provided in Nevada and no other payer is legally responsible for the qualifying forensic examination charge.
6. The administering agency shall establish a timely process for provider or program reconsideration or administrative review of a denied, reduced or recategorized claim. A payment dispute between a provider or program and the administering agency must not result in the qualifying patient becoming financially responsible for covered forensic examination services.
7. The administering agency shall publish and maintain current reimbursement categories, covered and excluded service components, applicable modifiers or adjustments, administrative eligibility requirements, claims instructions and maximum reimbursement amounts sufficient to permit providers and programs to understand the payment methodology before submitting claims.

Section 16. Aggregate data and legislative reporting.

1. The administering agency shall collect data sufficient to evaluate utilization, statewide access and fiscal impact.
2. At least annually, the administering agency should publish or submit to the Legislature aggregate information regarding the number and type of qualifying examinations, geographic distribution, provider or program type, amounts reimbursed, and available funding sources.
3. Public reports must not contain patient-identifying information, forensic photographs, detailed patient narratives, or information that would reasonably permit identification of a patient.

Section 17. Preservation of existing rights and responsibilities.

1. Nothing in this act diminishes any right, benefit, service, reporting option, advocacy right, evidentiary protection or source of payment otherwise available under NRS 217.280 to 217.350, Chapter 178A of NRS, NRS 217.405 or other applicable law.
2. A forensic medical examination qualifying under NRS 217.300 and a strangulation forensic medical examination qualifying under NRS 217.405 are qualifying medical forensic examinations for purposes of the umbrella payment framework.
3. Nothing in this act creates a new criminal offense, changes the elements of an existing offense, determines whether criminal conduct occurred, establishes probable cause, changes the burden of proof, or alters the admissibility or evidentiary weight of medical forensic findings.
4. Nothing in this act alters mandatory reporting duties or relieves any hospital, insurer, public program, governmental entity or other payer of a financial obligation otherwise imposed by law. Duplicate payment for the same service is prohibited.
5. Payment under this Act does not, by itself, authorize disclosure of a medical forensic record, forensic photograph, body diagram, video recording or other health care record to a law-

enforcement agency, prosecutor, compensation program or other person. Access, use and disclosure remain governed by otherwise applicable state and federal law, patient consent, mandatory-reporting requirements, court process and evidentiary requirements.

6. Nothing in this Act alters existing Nevada requirements governing collection, preservation, storage, transfer or submission of physical evidence, including sexual-assault evidence kits or other evidence required to be handled under separate law.

Section 18. Conforming amendment to NRS 217.160.

Amend NRS 217.160(1)(f) to authorize the compensation officer to order payment directly to a medical provider or eligible medical forensic program for a qualifying medical forensic examination performed pursuant to the new umbrella section, including examinations currently authorized under NRS 217.300 and NRS 217.405.

Section 19. Relationship to NRS 217.300 and NRS 217.405.

LCB should determine the most effective conforming structure. The preferred policy approach is to preserve crime-specific substantive protections in NRS 217.300 and NRS 217.405 while directing the payment component of those examinations to the new statewide umbrella framework. This approach avoids inadvertent loss of sexual-assault or strangulation protections while reducing duplicative payment provisions.

Section 20. Transition and implementation.

1. The administering agency should establish an implementation period sufficient to adopt administrative regulations, publish reimbursement schedules, establish administrative recognition criteria for examination categories and patient populations, develop claims procedures and complete the initial cost analysis required by this Act. Administrative implementation must not create or expand clinical scope of practice or replace applicable professional standards.

2. During the implementation period, providers and programs lawfully providing and receiving reimbursement for sexual-assault or strangulation forensic medical examinations immediately before the effective date of this Act should remain eligible for payment for those existing examination categories while the administering agency completes the new administrative recognition process, subject to continued compliance with applicable law and existing professional standards.

3. The administering agency may phase in newly covered examination categories when necessary to ensure that reimbursement methodology, claims infrastructure, administrative processes and statewide referral pathways are in place and that participating providers or programs can demonstrate the clinical qualifications required by applicable law and professional standards.

Section 21. Construction.

This act must be construed to promote timely, medically appropriate, trauma-informed, patient-centered and geographically equitable access to medical forensic examination services and to prevent the reimbursable cost of a qualifying medical forensic examination from being imposed upon the patient.

V. Understanding the Medical Forensic Examination

A medical forensic examination is a specialized health care encounter that combines clinical assessment with forensic functions. It is not synonymous with an evidence kit, forensic photography, or an ordinary emergency department examination. The examination is patient-centered health care first, while also preserving objective information that may later have investigative or evidentiary significance. The clinical and forensic components vary according to the patient's age, history,

presentation, mechanism or mechanisms of violence, timing, health needs, developmental status and safety concerns.

Depending on the circumstances, a medical forensic examination may include a detailed medical forensic history; assessment of the reported mechanism of injury or violence; head-to-toe examination; anogenital examination when indicated; neurologic, airway, voice, swallowing, vascular or other mechanism-specific assessment; identification and documentation of positive and negative findings; body diagrams; forensic photography; alternate light source examination when appropriate; biological, trace or toxicological evidence collection; pregnancy or infection-related assessment; medications or prophylaxis; safety assessment; mandatory reporting; consultation; discharge instructions; referrals; follow-up; evidence packaging and transfer; and extensive written documentation completed during or after the patient encounter.

The value of the examination does not depend on whether injury is identified. A medically appropriate examination may document injury, normal findings, nonspecific findings, pertinent negative findings, or the absence of visible injury. The absence of visible injury does not establish that an examination was unnecessary, that violence did not occur, or that the provider failed to perform a complete medical forensic assessment.

Medical forensic documentation also requires a level of detail and neutrality that differs from routine clinical charting. The record may later be reviewed by treating clinicians, law enforcement, prosecutors, defense counsel, courts or other authorized entities. Accordingly, qualified providers must be prepared to document history, examination findings, photographs, evidence-related procedures, clinical decision-making and follow-up in a manner that is medically accurate, objective and capable of independent review.

VI. Why Examination Type and Complexity Matter

Medical forensic examinations are not interchangeable. Different mechanisms of violence require different histories, examination techniques, documentation, evidence considerations, treatment needs, consultation requirements and follow-up. For this reason, a single flat reimbursement amount for every medical forensic examination may not reflect the actual resources necessary to provide competent care.

- Acute sexual assault or sexual abuse examination. May include a detailed assault history; head-to-toe and anogenital assessment when indicated; forensic evidence collection; forensic photography; pregnancy and infection-related assessment; toxicology considerations; medications or prophylaxis; chain-of-custody procedures; discharge planning; and extensive documentation.
- Strangulation or suffocation examination. May include mechanism-specific history; assessment of voice, swallowing, breathing, neurologic symptoms, loss or alteration of consciousness and vascular-risk symptoms; detailed examination of the head, face, eyes, oral cavity and neck; photography; neurologic assessment; treatment or imaging coordination when indicated; safety planning; and strangulation-specific discharge and follow-up instructions.
- Physical assault or interpersonal violence examination. May emphasize injury pattern, location, distribution, mechanism, functional complaints, body mapping, photography, blunt or sharp force considerations, defensive injuries, head trauma assessment, and documentation of both positive and negative findings.
- Child maltreatment or nonacute sexual abuse examination. May require developmentally appropriate history, specialized examination techniques, interpretation of findings in relation to age and development, photography, consultation, mandated reporting, caregiver education, safety assessment and multidisciplinary coordination.
- Older-person or vulnerable-person maltreatment examination. May involve injury documentation, functional and cognitive considerations, medication and comorbidity review, assessment for

neglect or exploitation, caregiver or facility context, photography, safety planning, reporting and coordination with protective services.

- Human trafficking examination. May involve multiple forms of violence or exploitation, chronic and acute health needs, sexual and physical assault assessment, strangulation assessment, injury documentation, infection and reproductive health needs, safety planning, trauma-informed communication, and coordination with appropriate services.
- Forensic follow-up or specialist consultation. May be necessary for reassessment of evolving findings, repeat photography, review of symptoms, treatment follow-up, interpretation of specialized findings, support of an onsite clinician, or continuity of forensic care.

VII. Multi-Mechanism and Evolving Examinations

Medical forensic examinations frequently evolve as the patient's history is obtained and the examination progresses. The initial referral or presenting complaint may not identify every mechanism of violence that requires assessment. A patient referred for a domestic physical assault, for example, may disclose during a structured medical forensic history that pressure was applied to the neck, that breathing was impeded, that the patient experienced voice or swallowing changes, or that other circumstances occurred requiring a strangulation or suffocation assessment. A patient presenting after a physical assault may also disclose sexual violence, head trauma, use of a weapon, loss or alteration of consciousness, or other mechanisms that require additional specialized evaluation.

The appropriate medical forensic examination should therefore be determined by the patient's history, clinical presentation, mechanisms disclosed or identified during the encounter, and the qualified provider's assessment of the patient's medical and forensic needs. The examination should not be restricted by the offense label, initial referral reason or information first provided to the examining clinician.

A single encounter may appropriately include evaluation of more than one mechanism of violence. Reimbursement methodology should recognize these multi-mechanism examinations through an appropriate complexity category or modifier when the additional history, examination, documentation, photography, evidence-related services, consultation, treatment coordination or follow-up materially increases the work required.

VIII. Program Capability, Patient Population and Scope-Appropriate Practice

The word "Comprehensive" in the title of the Nevada Comprehensive Forensic Examination Act describes the breadth of the statewide statutory framework. It does not mean that every individual examination must be comprehensive, nor does it mean that every provider or program is expected or authorized to evaluate every patient population or perform every category of medical forensic examination.

Medical forensic practice is population-specific and competency-based. A program may be appropriately qualified to provide adult and adolescent sexual assault, strangulation and physical assault examinations while not being qualified to conduct prepubertal child sexual abuse examinations. A pediatric specialty program may provide child maltreatment and nonacute sexual abuse evaluations but not acute adult sexual assault care. Other programs may provide focused examinations, follow-up services or consultation within a defined scope.

Statewide access therefore does not require identical capability at every location. A coordinated statewide system may include full examination sites for defined populations, focused examination sites, sites supported by real-time telehealth consultation, stabilization and referral sites, and specialty referral centers for patient populations or examination types requiring additional expertise.

When a patient's needs exceed the examining provider's or program's clinical capability, appropriate consultation, transfer or referral is part of evidence-based, scope-appropriate medical forensic care. The reimbursement framework should support that continuum rather than create an incentive for a program to perform services for which it lacks the necessary training, competency, infrastructure or patient-population expertise.

For reimbursement purposes, qualification should attach to the authorized examination category and patient population, not merely to the fact that an organization identifies itself as a medical forensic program. Administrative recognition for reimbursement should permit programs to be recognized for one or more categories of service when they demonstrate appropriate clinical qualifications under applicable law and professional standards, and programs should maintain defined referral pathways for needs outside those categories.

IX. Patient Autonomy, Timing, Records and Continuity of Care

Patient autonomy is central to medical forensic care. A patient may agree to some parts of an examination and decline others. A decision not to undergo photography, anogenital examination, evidence collection, toxicology testing, medication or another component does not negate the health care already provided and should not convert an otherwise qualifying medical forensic encounter into a nonreimbursable service.

Medical forensic care also should not be constrained by a rigid evidence-collection time window. Although some evidence may be more probative or collectable within particular timeframes, medical and forensic needs may persist beyond those intervals. Injury assessment, strangulation evaluation, documentation of evolving findings, child maltreatment assessment, safety planning, follow-up and referral may remain appropriate after an evidence-collection window has passed.

A focused or partial examination may be clinically appropriate. An examination may be limited by the patient's choices, the clinical question, the provider's scope and competency, the program's patient population, or the need to transfer the patient for services that require a higher level of medical care. Reimbursement policy should recognize the qualifying work actually performed rather than require every possible component to be completed.

Medical forensic records and photographs remain health care and forensic records subject to applicable privacy, consent, mandatory-reporting, subpoena, evidentiary and evidence-transfer requirements. State payment for the examination should not be interpreted as automatic ownership of, or unrestricted access to, the patient's complete forensic record or photographs by the payer, law enforcement or another agency.

Appropriate referral and transfer are part of safe forensic practice. A community-based forensic program may complete history, examination, injury documentation and photography and then refer a patient to an emergency department for advanced imaging or other ordinary medical care. The forensic program should remain reimbursable for the qualifying services it performed, while the receiving facility bills the legally responsible payer for ordinary medical care and any additional qualifying forensic services actually provided.

The medical forensic history serves a clinical and forensic assessment purpose and should remain distinct from an investigative interview. The examiner obtains information necessary to evaluate health needs, mechanisms of injury or violence, evidence considerations, safety and follow-up; the examiner is not acting as a substitute law-enforcement interrogator or child forensic interviewer.

X. Nevada Reimbursement Benchmarks and Legislative History

Nevada already has an established reimbursement framework for sexual-assault forensic medical examinations and strangulation forensic medical examinations. The final 2025 enactment of S.B. 87 requires the state administering entity to review and establish the maximum annual reimbursement rate for each examination type rather than permanently placing a fixed dollar amount in statute. This annual-rate approach should be preserved and expanded to the additional examination categories contemplated by this Act.

During the 2025 legislative process, proposed reimbursement caps of $1,000 for a sexual-assault forensic medical examination and $1,500 for a strangulation forensic medical examination appeared in amendment language. Those figures are useful as legislative history and reimbursement benchmarks, but they should not be represented as permanent current statutory rates. Before introduction of this proposal, the current state reimbursement schedule for both examination types should be obtained and incorporated into the fiscal materials.

Existing sexual-assault and strangulation reimbursement should serve as reference points, not automatic rates for all other examinations. Newly covered examination categories should be evaluated according to the actual resources necessary to provide competent medical forensic care. A physical-assault examination, child maltreatment examination, trafficking examination, vulnerable-adult examination or multi-mechanism encounter may require substantially different provider time, documentation, equipment, consultation, readiness and follow-up.

XI. Methodology for Establishing Reimbursement Rates

The central reimbursement principle should be that payment reflects the reasonable cost of maintaining and delivering a qualified medical forensic service, not merely the minutes during which the clinician is physically examining the patient. Medical forensic capacity requires trained clinicians, on-call availability, specialized equipment, documentation systems, quality review, competency maintenance, evidence-related supplies and administrative infrastructure even when no examination is actively in progress.

- Professional clinical time: history, examination, evidence-related procedures, treatment coordination, discharge, consultation and post-encounter documentation.
- Forensic complexity: mechanism-specific assessment, multiple mechanisms of violence, developmental or cognitive considerations, extensive injury documentation or unusually complex evidence issues.
- Documentation burden: detailed narrative documentation, body diagrams, forensic photography, image management, evidence inventories and chain-of-custody documentation.
- Supplies and bundled services: evidence-related supplies, personal protective equipment, swabs, point-of-care testing, designated medications, prophylaxis and other items included in the forensic bundle.
- Readiness and on-call capacity: costs necessary to maintain timely access to qualified medical forensic clinicians, including periods when clinicians are available but not actively performing an examination.
- Training and quality infrastructure: initial education, supervised clinical preparation, competency validation, continuing education, peer or quality review, equipment maintenance, secure storage and program oversight.
- Geographic access: reasonable adjustments for rural, frontier, tribal or other underserved areas where staffing, travel, telehealth support or low examination volume may increase the cost of maintaining access.

- Consultation and follow-up: separate or bundled reimbursement for specialist consultation, telehealth support, follow-up examination, repeat photography or reassessment when clinically and forensically indicated.
- Administrative costs: claims processing, program administration, scheduling, coordination, evidence transfer and other reasonable costs directly necessary to operate a medical forensic service.

The administering agency should be authorized to use bundled rates, tiered complexity levels, professional and program/facility components, extended-examination modifiers, multi-mechanism modifiers and geographic access adjustments. The final methodology should avoid incentives to fragment one clinically appropriate examination into multiple billable encounters while also avoiding underpayment when a single encounter becomes substantially more complex than the initial referral suggested.

XII. Suggested Reimbursement Structure for Fiscal Modeling

For fiscal modeling, the following structure may be more useful than assigning one flat amount to each crime type. The tiers are policy-development concepts and should not be treated as final statutory classifications.

- Tier I - Focused medical forensic examination: limited injury documentation, focused physical-assault examination, limited reassessment or other lower-complexity forensic service.
- Tier II - Comprehensive medical forensic examination: extensive physical assault, strangulation or suffocation, vulnerable-adult maltreatment, trafficking or other examinations requiring broader mechanism-specific assessment and documentation.
- Tier III - Complex or specialized medical forensic examination: acute sexual assault, pediatric sexual abuse or maltreatment, complex trafficking, multi-mechanism violence, extensive evidence collection or other encounters requiring substantial specialized assessment and documentation.
- Follow-up medical forensic examination: reassessment, evolving injury documentation, repeat photography, treatment follow-up or related forensic continuity of care.
- Telehealth or specialist medical forensic consultation: real-time support of an onsite clinician or qualifying specialist consultation.
- Extended-complexity or multi-mechanism modifier: additional reimbursement when the encounter materially exceeds the expected work of the base examination category.
- Rural/frontier access modifier or readiness adjustment: additional support when necessary to maintain access in low-volume or geographically isolated settings.

XIII. Professional, Program and Facility Components

The reimbursement model should expressly evaluate whether payment is intended to compensate only the individual clinician’s professional service or also the program and facility infrastructure necessary to make the examination available. Hospital-based and community-based medical forensic programs may incur costs for examination space, registration, supplies, secure forensic photography systems, evidence storage and transfer, laboratory coordination, scheduling, on-call systems, equipment maintenance, quality review, administrative support and other operational requirements.

DHHS and fiscal staff should determine whether Nevada is best served by a single global bundled payment, separate professional and program/facility components, or another methodology that prevents duplicate billing while reasonably reimbursing the entities actually providing the service. The model should be sufficiently flexible to support hospital-based, community-based, pediatric, rural, frontier and telehealth-supported forensic programs.

XIV. Initial Rate Study and Stakeholder Process

Before the expanded examination categories become effective, DHHS should conduct or obtain an initial cost study and develop a published reimbursement schedule. The study should use Nevada-specific data whenever available and should examine current sexual-assault and strangulation reimbursement, actual provider and program costs, average examination and documentation time, supply costs, on-call and readiness expense, consultation and follow-up needs, geographic access and comparable approaches used by other jurisdictions.

The initial rate-development process should include clinicians and programs that actually provide medical forensic care. At a minimum, consultation should include hospital-based and community-based forensic programs, forensic nurses and physicians, advanced practice clinicians, pediatric specialists, vulnerable-adult providers, rural/frontier programs, the Victims of Crime Program, Nevada Medicaid, victim-service organizations and other affected stakeholders.

Rates should then be reviewed at least annually, consistent with Nevada's existing approach for sexual-assault and strangulation examinations, with adjustments when necessary to reflect material changes in labor, supplies, medications, technology, regulatory requirements, access needs or the cost of maintaining qualified forensic services.

XV. Reimbursement Framework for Fiscal Development

The Act should authorize DHHS to establish rates rather than placing dollar amounts in statute. For fiscal modeling and stakeholder discussion, the following service categories should be evaluated separately:

- Acute sexual assault / sexual abuse examination
- Nonacute sexual abuse examination
- Strangulation / suffocation examination
- Physical assault / interpersonal violence examination
- Child maltreatment medical forensic examination
- Older-person / vulnerable-person maltreatment examination
- Human trafficking medical forensic examination
- Forensic follow-up examination
- Telehealth / specialist medical forensic consultation

For each category, fiscal staff should identify the expected provider time, on-call costs, documentation and photography burden, evidence-related supplies, medications or tests included in the bundle, consultation needs, follow-up services, quality requirements, and administrative costs. High-cost general medical services such as advanced imaging, surgery and hospitalization should ordinarily remain outside the forensic bundle unless specifically designated otherwise.

XVI. Claims and Funding Structure — Recommended Position

- Direct provider or program billing to the Victims of Crime Compensation payment mechanism.
- No requirement that the patient first submit an ordinary compensation application solely for the forensic examination.
- No routine submission of the complete forensic record or photographs for payment.
- No patient balance billing for covered forensic services.
- No duplicate payment for the same service.
- VOCA Victim Compensation may be used when legally allowable; VOCA Victim Assistance should not be characterized as a general medical-bill payer.

- If the Fund is insufficient, use a statewide appropriation or reserve rather than a county-by-county backstop for the qualifying examination payment obligation.

XVII. Stakeholders for Legislative Development

- Nevada agency or program responsible for administration of the Fund for the Compensation of Victims of Crime
- Nevada Legislative Counsel Bureau and fiscal staff
- Hospitals and emergency medical facilities
- Medical forensic nursing and physician programs
- Child advocacy centers and child-abuse medical programs
- Adult Protective Services and child welfare agencies
- Domestic violence, sexual assault, trafficking and victim-service organizations
- Nevada Medicaid and other public payers
- County governments
- Law enforcement, prosecutors and crime laboratory representatives
- Tribal health and tribal justice partners
- Professional boards and organizations representing affected health care providers

XVIII. Legislative Rationale and Talking Points

Nevada already has the payment infrastructure. The 2025 statutory framework authorizes direct payment for sexual-assault and strangulation forensic medical examinations. The Act does not create an unrelated payment system; it extends an existing forensic-provider reimbursement structure to additional qualifying examination categories.

The offense label should not determine access. Victims of physical assault, child maltreatment, vulnerable-adult abuse, trafficking and other crimes may have medical and forensic needs comparable to those of patients presenting after sexual assault or strangulation. Access to a qualified forensic examination should follow the clinical and forensic need, not whether the crime falls within one of the two categories that currently has an express direct-payment pathway.

Reimbursement determines whether services can be offered. The present gap is not simply that a provider lacks a billing code after an examination has already occurred. Without a reliable mechanism to reimburse the forensic provider or program, many additional classes of examination may not be developed, staffed or offered at all. The Act creates the financial pathway necessary for qualified programs to make those services available.

This is a forensic-service payment issue, not a proposal to shift ordinary medical care to the Victims of Crime Fund. The Act reimburses the specialized medical forensic examination performed by the qualified forensic provider or program. Emergency treatment, imaging, hospitalization, surgery and other ordinary medical services remain the responsibility of the otherwise applicable medical payer unless specifically included in a forensic reimbursement category.

The examination may evolve during the encounter. A patient referred for a domestic physical assault may disclose strangulation, suffocation, sexual violence, head trauma or another mechanism only after a qualified medical forensic history is obtained. The reimbursement framework must therefore follow the actual medical forensic work performed rather than the initial referral label.

Reimbursement supports capacity as well as the completed examination. Sustainable statewide access requires trained clinicians, competency maintenance, on-call readiness, specialized equipment, secure documentation systems, quality review and administrative infrastructure. A rate based only on face-to-face examination minutes risks underfunding the very capacity the Act is intended to create.

The examination is broader than evidence collection. Medical forensic care may include health assessment, injury documentation, photography, evidence-related services, treatment coordination, discharge planning, consultation and follow-up even when no evidence kit is collected.

Patient choice does not erase the examination. A patient may consent to selected components and decline others; reimbursement should follow the medically and forensically appropriate services actually provided rather than require a patient to complete every possible component.

Evidence windows are not care windows. Time-sensitive evidence considerations may affect what evidence is collected, but they should not create an arbitrary cutoff for injury assessment, strangulation evaluation, documentation, follow-up, child maltreatment assessment or other medically indicated forensic care.

Payment does not equal ownership of the record. The fact that the State reimburses the forensic examination should not automatically authorize access to the patient's complete medical forensic record or photographs; disclosure remains governed by applicable law and consent.

The proposal separates forensic services from ordinary medical care. The Fund pays the specialized forensic component; ordinary emergency treatment, hospitalization, imaging, surgery and unrelated care remain with the legally responsible health care payer unless specifically included in a reimbursement category.

Comprehensive statewide coverage does not mean every program does everything. Providers and programs should be recognized by patient population and examination category, and should provide only those services supported by lawful scope of practice, demonstrated competency, appropriate infrastructure and evidence-based or evidence-informed practice. Consultation and referral are expected components of a safe statewide system.

The Act protects statewide equity. A statewide payment obligation should have a statewide fiscal backstop rather than depend on the county in which the offense occurred.

The Act does not decide whether a crime occurred. The examination is a health care and forensic service. Payment eligibility does not establish probable cause, guilt, causation, or evidentiary admissibility.

The Act preserves reporting law. Nothing changes mandatory reporting, consent, protective custody or other duties applicable to children, vulnerable adults or other patients.

EFCA is a policy analogue, not the Nevada bill. The federal proposal demonstrates recognition of broader medical forensic capacity across interpersonal violence; Nevada's Act is independently titled and structured around Nevada's own compensation framework.

XIX. Fiscal and Implementation Information to Obtain Before Introduction

- Annual number of sexual-assault and strangulation examinations currently reimbursed, by examination category, county/region and provider type.
- Current maximum reimbursement rates and the historical proportion paid with state versus federal Victim Compensation funds.
- Obtain the current DHHS maximum annual reimbursement rate for sexual-assault forensic medical examinations and strangulation forensic medical examinations; compare those current rates with the $1,000 and $1,500 benchmarks considered during the 2025 S.B. 87 legislative process.
- Complete a Nevada-specific cost analysis for each newly covered examination category before setting the initial reimbursement schedule, including professional time, documentation time, readiness/on-call costs, program/facility infrastructure, supplies, quality requirements and geographic access.

- Model tiered rates and modifiers for focused, comprehensive, complex, multi-mechanism, extended-duration, follow-up, consultation and rural/frontier examinations.
- Projected volume for newly eligible examination categories, including physical assault, child maltreatment, older/vulnerable-person maltreatment and trafficking.
- Potential effect of additional qualifying compensation expenditures on future federal VOCA Victim Compensation awards, subject to federal certification and eligibility rules.
- Cost of replacing the county backstop with a statewide appropriation or reserve.
- Proposed bundled services and exclusions for each reimbursement category.
- Administrative cost of credentialing/qualification, claims processing, data collection and annual reporting.
- Potential geographic-access effects, including rural, frontier and tribal communities and the role of telehealth consultation.
- Define category-specific and population-specific provider/program qualification criteria, including referral pathways for examination types or patient populations outside a site's capability.
- Develop patient-consent standards addressing component-specific consent, refusal and withdrawal without loss of examination eligibility.
- Define privacy and disclosure rules for medical forensic records and photographs, including the effect of state payment and preservation of existing evidence-transfer statutes.
- Establish claims reconsideration or appeal procedures and require publication of reimbursement schedules, covered services, exclusions and modifiers.
- Establish transition provisions so existing sexual-assault and strangulation programs are not disrupted while new qualification standards and reimbursement categories are implemented.
- Clarify reimbursement for focused, partial, interrupted, referred and transferred examinations and prohibit financial penalties for appropriate scope-based referral.
- Confirm that Nevada residency is not required when the qualifying examination is provided in Nevada and no other forensic payer is legally responsible.

XX. One-Page Legislative Concept Summary

Proposed title: Nevada Comprehensive Forensic Examination Act

Purpose: Establish a statewide direct-reimbursement mechanism so qualified forensic providers and programs can make medically and forensically indicated examinations available to persons affected by criminal violence, abuse, neglect or exploitation, without limiting access to the particular offense classification and without billing the patient for reimbursable forensic examination services.

Current gap: Nevada provides a direct forensic-provider payment pathway for sexual-assault forensic medical examinations under NRS 217.300 and strangulation forensic medical examinations under NRS 217.405. Other victims may have comparable specialized forensic needs, but qualified forensic providers and programs do not have the same express reimbursement pathway for those examination categories. Without a viable reimbursement mechanism, those services may not be developed, staffed or offered.

Proposal: Create an umbrella medical forensic examination statute covering qualifying patients when a qualified medical provider determines that specialized medical forensic evaluation is medically or forensically indicated. Examples include sexual violence, strangulation/suffocation, domestic violence, physical assault, child abuse/neglect, older or vulnerable-person maltreatment, trafficking and other criminal violence.

Payment: Direct payment to the qualified forensic provider or program from the Fund for the Compensation of Victims of Crime at annually established reimbursement rates, with lawful use of federal VOCA Victim Compensation funds and a statewide state-funded backstop if the Fund is

insufficient. The purpose is to make specialized forensic examinations financially sustainable across qualifying crime types; it is not a replacement for ordinary medical billing. No balance billing for reimbursed forensic examination services.

Scope boundary: The Act pays the specialized medical forensic component. Ordinary medical treatment—such as hospitalization, surgery, advanced imaging and unrelated general care—remains payable through the legally responsible health care payer unless specifically incorporated into a forensic reimbursement category.

Access protections: No requirement for a police report, arrest, prosecution, conviction, visible injury, agency substantiation, evidence kit or laboratory submission. Eligibility is based on the medical and forensic indication for the examination, not the final criminal charge.

Patient autonomy and continuity: A patient may accept or decline individual examination components without automatically losing eligibility. No arbitrary evidence-window cutoff controls access to medically or forensically indicated care, and focused or transferred examinations remain eligible when appropriate.

Record protection: State payment does not itself authorize disclosure of the patient's medical forensic record or photographs. Existing privacy, consent, reporting, subpoena and evidence-transfer law continues to govern access and disclosure.

Quality and accountability: DHHS establishes proportionate provider/program standards, differentiated reimbursement categories, a streamlined direct-provider claims process and aggregate reporting without public disclosure of patient-identifying information.

Scope-appropriate delivery: Programs are approved for defined examination categories and patient populations. The Act does not presume universal capability; services outside a program's competency or infrastructure are addressed through consultation, transfer or referral.

Why now: Nevada has already established the infrastructure to reimburse specialized medical forensic examinations for sexual assault and strangulation. The remaining gap is the limited number of examination categories currently eligible to use that mechanism. Expanding eligibility would allow qualified forensic providers and programs to develop and sustain evidence-based examination services for other victims of crime and would align reimbursement with medical and forensic need rather than with a narrow set of offense categories.

XXI. Authorities and Source Notes

Nev. Rev. Stat. § 217.160 (current through 2025 amendments) (authorizing direct payment to medical providers for examinations under NRS 217.300 and NRS 217.405).

Nev. Rev. Stat. § 217.300 (current through 2025 amendments) (sexual-assault forensic medical examination payment; Fund payment; county backstop if Fund insufficient; law-enforcement report not prerequisite; annual reimbursement rate).

Nev. Rev. Stat. § 217.405 (current through 2025 amendments) (strangulation forensic medical examination payment; no direct charge to victim; Fund payment; county backstop if Fund insufficient; annual reimbursement rate).

Nev. Rev. Stat. § 178A.190 (sexual-assault survivor payment protection related to forensic medical examination).

Nev. S.B. 87, 83d Leg. (2025) (revising direct payment for sexual-assault and strangulation forensic medical examinations through the Fund for the Compensation of Victims of Crime).

Nev. S.B. 87 legislative amendment materials (2025) (including proposed reimbursement caps of $1,000 for sexual-assault forensic medical examinations and $1,500 for strangulation forensic medical

examinations during the legislative process; final enacted law instead directs the responsible state entity to establish maximum reimbursement rates annually).

Ensuring Forensic Care for All Victims Act, S. 2655, 117th Cong. (2021) (federal demonstration-grant proposal supporting clinical training for medical forensic examinations and treatment of survivors of interpersonal violence of all ages).

34 U.S.C. § 20102 (Crime Victim Compensation; federal grants to eligible state compensation programs and qualifying compensation for medical expenses attributable to compensable crime).