REQUIRES TWO-THIRDS MAJORITY VOTE (§ 3)

S.B. 320

SENATE BILL NO. 320–SENATOR SHAFFER (BY REQUEST)

MARCH 17, 2003

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes to provisions governing industrial insurance. (BDR 53-600)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to industrial insurance; establishing a system of external review for certain matters relating to industrial insurance; providing for the regulation and certification of certain external review organizations; providing for the payment of certain regulatory fees by external review organizations; authorizing an organization for managed care to charge an administrative fee to providers of health care under certain circumstances; requiring the adoption of certain medical standards for evaluating permanent impairments to injured employees; revising various provisions relating to medical treatment of injured employees; revising various provisions relating to the processing of claims and the payment of compensation to injured employees; revising certain procedures and establishing certain requirements relating to the adjudication of contested claims; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. ***"External review organization" means an organization which has been issued a certificate pursuant to section 3 of this act that authorizes the organization to conduct***

external reviews for the purposes of chapters 616A to 616D, inclusive, of NRS.

Sec. 3. *1. If the Administrator determines that an external review organization is qualified to conduct external reviews for the purposes of chapters 616A to 616D, inclusive, of NRS, the Administrator shall issue a certificate to the external review organization that authorizes the organization to conduct such external reviews in accordance with the provisions of section 6 of this act and the regulations adopted by the Administrator.*

2. The Administrator shall adopt regulations setting forth the procedures that an external review organization must follow to be issued a certificate to conduct external reviews. The regulations must include, without limitation, provisions setting forth:

(a) The manner in which an external review organization may apply for a certificate and the requirements for the issuance and renewal of the certificate pursuant to this section;

(b) The grounds for which the Administrator may refuse to issue, suspend, revoke or refuse to renew a certificate issued pursuant to this section;

(c) The manner and circumstances under which an external review organization is required to conduct its business; and

(d) A fee for issuing or renewing a certificate of an external review organization pursuant to this section. The fee must not exceed the cost of issuing or renewing the certificate.

3. A certificate issued pursuant to this section expires 1 year after it is issued and may be renewed in accordance with regulations adopted by the Administrator.

4. Before the Administrator may issue a certificate to an external review organization, the external review organization must:

(a) Demonstrate to the satisfaction of the Administrator that it is able to carry out, in a timely manner, the duties of an external review organization as set forth in section 6 of this act and the regulations adopted by the Administrator. The demonstration must include, without limitation, proof that the external review organization employs, contracts with or otherwise retains only persons who are qualified because of their education, training, professional licensing and experience to perform the duties assigned to those persons; and

(b) Provide assurances satisfactory to the Administrator that the external review organization will:

(1) Conduct external reviews in accordance with the provisions of section 6 of this act and the regulations adopted by the Administrator;

(2) Render its decisions in a clear, consistent, thorough and timely manner; and

(3) Avoid conflicts of interest.

5. For the purposes of this section, an external review organization has a conflict of interest if the external review organization or any employee, agent or contractor of the external review organization who conducts an external review has a professional, familial or financial interest of a material nature with respect to any person who has a substantial interest in the outcome of the external review, including, without limitation:

(a) The claimant;

(b) The employer; or

(c) The insurer or any officer, director or management employee of the insurer.

6. The Administrator shall not issue a certificate to an external review organization that is affiliated with:

(a) An organization for managed care;

(b) An insurer; or

(c) A national, state or local trade association.

7. An external review organization which is certified or accredited by an accrediting body that is nationally recognized shall be deemed to have satisfied all the conditions and qualifications required for the external review organization to be issued a certificate pursuant to this section.

Sec. 4. NRS 616A.025 is hereby amended to read as follows:

616A.025 As used in chapters 616A to 616D, inclusive, of NRS, unless the context otherwise requires, the words and terms defined in NRS 616A.030 to 616A.360, inclusive, ***and section 2 of this act*** have the meanings ascribed to them in those sections.

Sec. 5. NRS 616B.5285 is hereby amended to read as follows:

616B.5285 ***1. In any contract between an organization for managed care and a provider of health care, the organization for managed care may charge the provider of health care an administrative fee of not more than $200 per year for administrative costs and services associated with the contract, including, without limitation:***

(a) Investigating, reviewing, confirming or certifying the credentials of the provider of health care; and

(b) Providing education and support to the provider of health care.

2. An organization for managed care shall not terminate a contract with, demote, refuse to contract with or refuse to compensate a provider of health care solely because the provider, in good faith:

~~[1.]~~ ***(a)*** Advocates in private or in public on behalf of an injured employee;

~~[2.]~~ ***(b)*** Assists an injured employee in seeking reconsideration of a determination by the organization for managed care to deny coverage for a medical or health care service; or

~~[3.]~~ ***(c)*** Reports a violation of law to an appropriate authority.

Sec. 6. Chapter 616C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Not later than 5 days after the date that an appeals officer submits a matter to an external review organization pursuant to NRS 616C.360, the external review organization shall:

(a) Review the documents and materials submitted for the external review; and

(b) Notify the injured employee, his employer and the insurer whether the external review organization needs any additional information to conduct the external review.

2. The external review organization shall render a decision on the matter not later than 15 days after the date that it receives all information that is necessary to conduct the external review.

3. In conducting the external review, the external review organization shall consider, without limitation:

(a) The medical records of the insured;

(b) Any recommendations of the physician of the insured; and

(c) Any other information approved by the Administrator for consideration by an external review organization.

4. In its decision, the external review organization shall specify the reasons for its decision. The external review organization shall submit a copy of its decision to:

(a) The injured employee;

(b) The employer;

(c) The insurer; and

(d) The appeals officer.

5. The Administrator shall adopt regulations to govern the process of external review and to carry out the provisions of this section.

Sec. 7. NRS 616C.090 is hereby amended to read as follows:

616C.090 1. The Administrator shall establish a panel of physicians and chiropractors who have demonstrated special competence and interest in industrial health to treat injured employees under chapters 616A to 616D, inclusive, or chapter 617 of NRS. Every employer whose insurer has not entered into a contract with an organization for managed care or with providers of health care services pursuant to NRS 616B.527 shall maintain a list of those physicians and chiropractors on the panel who are reasonably accessible to his employees.

2. An injured employee whose employer's insurer has not entered into a contract with an organization for managed care or with providers of health care services pursuant to NRS 616B.527 may choose his treating physician or chiropractor from the panel of physicians and chiropractors. If the injured employee is not satisfied with the first physician or chiropractor he so chooses, he may make an alternative choice of physician or chiropractor from the panel if the choice is made within 90 days after his injury. The insurer shall notify the first physician or chiropractor in writing. The notice must be postmarked within 3 working days after the insurer receives knowledge of the change. The first physician or chiropractor must be reimbursed only for the services he rendered to the injured employee up to and including the date of notification. ~~[Except as otherwise provided in this subsection, any]~~ ***Any*** further change is subject to the approval of the insurer, which must be granted or denied within 10 days after a written request for such a change is received from the injured employee. If no action is taken on the request within 10 days, the request shall be deemed granted. Any request for a change of physician or chiropractor must include the name of the new physician or chiropractor chosen by the injured employee. ~~[If the treating physician or chiropractor refers the injured employee to a specialist for treatment, the treating physician or chiropractor shall provide to the injured employee a list that includes the name of each physician or chiropractor with that specialization who is on the panel. After receiving the list, the injured employee shall, at the time the referral is made, select a physician or chiropractor from the list.]~~

3. An injured employee whose employer's insurer has entered into a contract with an organization for managed care or with providers of health care services pursuant to NRS 616B.527 must choose his treating physician or chiropractor pursuant to the terms of that contract. If the injured employee is not satisfied with the first physician or chiropractor he so chooses, he may make an alternative choice of physician or chiropractor pursuant to the terms of the contract if the choice is made within 90 days after his injury. If the injured employee, after choosing his treating physician or chiropractor, moves to a county which is not served by the organization for managed care or providers of health care services named in the contract and the insurer determines that it is impractical for the injured employee to continue treatment with the physician or chiropractor, the injured employee must choose a treating physician or chiropractor who has agreed to the terms of that contract unless the insurer authorizes the injured employee to choose another physician or chiropractor. ~~[If the treating physician or chiropractor refers the injured employee to a specialist for~~

~~treatment, the treating physician or chiropractor shall provide to the injured employee a list that includes the name of each physician or chiropractor with that specialization who is available pursuant to the terms of the contract with the organization for managed care or with providers of health care services pursuant to NRS 616B.527, as appropriate. After receiving the list, the injured employee shall, at the time the referral is made, select a physician or chiropractor from the list. If the employee fails to select a physician or chiropractor, the insurer may select a physician or chiropractor with that specialization. If a physician or chiropractor with that specialization is not available pursuant to the terms of the contract, the organization for managed care or the provider of health care services may select a physician or chiropractor with that specialization.]~~

4. Except when emergency medical care is required and except as otherwise provided in NRS 616C.055, the insurer is not responsible for any charges for medical treatment or other accident benefits furnished or ordered by any physician, chiropractor or other person selected by the injured employee in disregard of the provisions of this section or for any compensation for any aggravation of the injured employee's injury attributable to improper treatments by such physician, chiropractor or other person.

5. The Administrator may order necessary changes in a panel of physicians and chiropractors and shall suspend or remove any physician or chiropractor from a panel for good cause shown.

6. An injured employee may receive treatment by more than one physician or chiropractor if the insurer provides written authorization for such treatment.

7. The Administrator shall design a form that notifies injured employees of their right pursuant to subsections 2 and 3 to select an alternative treating physician or chiropractor and make the form available to insurers for distribution pursuant to subsection 2 of NRS 616C.050.

Sec. 8. NRS 616C.110 is hereby amended to read as follows:

616C.110 1. For the purposes of NRS 616B.557, ***616B.578, 616B.587,*** 616C.490 and 617.459, the Division shall adopt regulations incorporating the American Medical Association's *Guides to the Evaluation of Permanent Impairment* ***, 4th Edition, 3rd Printing,*** by reference ***.*** ~~[and]~~ ***The Division*** may amend those regulations from time to time as it deems necessary ~~[. In adopting]~~ ***, except that the amendments to those regulations:***

(a) Must be consistent with the ***American Medical Association's*** *Guides to the Evaluation of Permanent Impairment*, ~~[the Division shall consider the edition most recently published by]~~ ***4th Edition, 3rd Printing; and***

(b) Must not incorporate any contradictory matter from any other edition or printing of the American Medical ~~[Association.]~~ ***Association's Guides to the Evaluation of Permanent Impairment.***

2. If the ***American Medical Association's*** *Guides to the Evaluation of Permanent Impairment* ~~[adopted by the Division contain]~~ ***, 4th Edition, 3rd Printing, contains*** more than one method of determining the rating of an impairment, the Administrator shall designate by regulation the method ***from that edition and printing*** which must be used to rate an impairment pursuant to NRS 616C.490.

Sec. 9. NRS 616C.175 is hereby amended to read as follows:

616C.175 1. The resulting condition of an employee who:

(a) Has a preexisting condition from a cause or origin that did not arise out of or in the course of his current or past employment; and

(b) Subsequently sustains an injury by accident arising out of and in the course of his employment which aggravates, precipitates or accelerates his preexisting condition,

shall be deemed to be an injury by accident that is compensable pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS, unless the insurer can prove by a preponderance of the evidence that the subsequent injury is not ~~[a substantial contributing]~~ ***the primary*** cause of the resulting condition.

2. The resulting condition of an employee who:

(a) Sustains an injury by accident arising out of and in the course of his employment; and

(b) Subsequently aggravates, precipitates or accelerates the injury in a manner that does not arise out of and in the course of his employment,

shall be deemed to be an injury by accident that is compensable pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS, unless the insurer can prove by a preponderance of the evidence that the injury described in paragraph (a) is not ~~[a substantial contributing]~~ ***the primary*** cause of the resulting condition.

Sec. 10. NRS 616C.245 is hereby amended to read as follows:

616C.245 1. Every injured employee within the provisions of chapters 616A to 616D, inclusive, of NRS is entitled to receive promptly such accident benefits as may reasonably be required at the time of the injury and within 6 months thereafter. Such benefits may be further extended for additional periods as may be required.

2. An injured employee is entitled to receive as an accident benefit a motor vehicle that is modified to allow the employee to operate the vehicle safely if:

(a) As a result of an injury arising out of and in the course of his employment, he is quadriplegic, paraplegic or has had a part of his body amputated; and

(b) He cannot be fitted with a prosthetic device which allows him to operate a motor vehicle safely.

3. If an injured employee is entitled to receive a motor vehicle pursuant to subsection 2, a motor vehicle must be modified to allow the employee to operate it safely in the following order of preference:

(a) A motor vehicle owned by the injured employee must be so modified if the insurer or employer providing accident benefits determines that it is reasonably feasible to do so.

(b) A used motor vehicle must be so modified if the insurer or employer providing accident benefits determines that it is reasonably feasible to do so.

(c) A new motor vehicle must be so modified.

4. The Administrator shall adopt regulations establishing a maximum benefit to be paid under the provisions of this section.

Sec. 11. NRS 616C.315 is hereby amended to read as follows:

616C.315 1. Any person who is subject to the jurisdiction of the hearing officers pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS may request a hearing before a hearing officer of any matter within the hearing officer's authority. The insurer shall provide, without cost, the forms necessary to request a hearing to any person who requests them.

2. ***A request for a hearing must be dismissed unless the request for a hearing includes:***

(a) The name and last known mailing address of:

(1) The claimant;

(2) The employer; and

(3) The insurer;

(b) The number of the claim; and

(c) A copy of the letter of determination being appealed, or if such a copy is unavailable, the date of the determination and the issues stated in the determination.

3. Except as otherwise provided in NRS 616B.772, 616B.775, 616B.787 and 616C.305, a person who is aggrieved by:

(a) A written determination of an insurer; or

(b) The failure of an insurer to respond within 30 days to a written request mailed to the insurer by the person who is aggrieved,

may appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer. Such a request must be filed within 70 days after the date on which the notice of the insurer's determination was mailed by the insurer or the unanswered

written request was mailed to the insurer, as applicable. The failure of an insurer to respond to a written request for a determination within 30 days after receipt of such a request shall be deemed by the hearing officer to be a denial of the request.

~~[3.]~~ ***4.*** Failure to file a request for a hearing within the period specified in subsection ~~[2]~~ ***3*** may be excused if the person aggrieved shows by a preponderance of the evidence that he did not receive the notice of the determination and the forms necessary to request a hearing. The claimant or employer shall notify the insurer of a change of address.

~~[4.]~~ ***5.*** The hearing before the hearing officer must be conducted as expeditiously and informally as is practicable.

~~[5.]~~ ***6.*** The parties to a contested claim may, if the claimant is represented by legal counsel, agree to forego a hearing before a hearing officer and submit the contested claim directly to an appeals officer.

Sec. 12. NRS 616C.345 is hereby amended to read as follows:

616C.345 1. Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by filing a notice of appeal with an appeals officer within 30 days after the date of the decision.

2. ***A request for a hearing must be dismissed unless the request for a hearing includes:***

(a) The name and last known mailing address of:

(1) The claimant;

(2) The employer; and

(3) The insurer;

(b) The number of the claim; and

(c) A copy of the letter of determination being appealed, or if such a copy is unavailable, the date of the determination and the issues stated in the determination.

3. If a dispute is required to be submitted to a procedure for resolving complaints pursuant to NRS 616C.305 and:

(a) A final determination was rendered pursuant to that procedure; or

(b) The dispute was not resolved pursuant to that procedure within 14 days after it was submitted,

any party to the dispute may file a notice of appeal within 70 days after the date on which the final determination was mailed to the employee, or his dependent, or the unanswered request for resolution was submitted. Failure to render a written determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request.

~~[3.]~~ ***4.*** Except as otherwise provided in NRS 616C.380, the filing of a notice of appeal does not automatically stay the

enforcement of the decision of a hearing officer or a determination rendered pursuant to NRS 616C.305. The appeals officer may order a stay, when appropriate, upon the application of a party. If such an application is submitted, the decision is automatically stayed until a determination is made concerning the application. A determination on the application must be made within 30 days after the filing of the application. If a stay is not granted by the officer after reviewing the application, the decision must be complied with within 10 days after the date of the refusal to grant a stay.

~~[4.]~~ ***5.*** Except as otherwise provided in this subsection, the appeals officer shall, within 10 days after receiving a notice of appeal pursuant to this section or a contested claim pursuant to subsection ~~[5]~~ ***6*** of NRS 616C.315, schedule a hearing on the merits of the appeal or contested claim for a date and time within 90 days after his receipt of the notice and give notice by mail or by personal service to all parties to the matter and their attorneys or agents at least 30 days before the date and time scheduled. A request to schedule the hearing for a date and time which is:

(a) Within 60 days after the receipt of the notice of appeal or contested claim; or

(b) More than 90 days after the receipt of the notice or claim,

may be submitted to the appeals officer only if all parties to the appeal or contested claim agree to the request.

~~[5.]~~ ***6.*** An appeal or contested claim may be continued upon written stipulation of all parties, or upon good cause shown.

~~[6.]~~ ***7.*** Failure to file a notice of appeal within the period specified in subsection 1 or ~~[2]~~ ***3*** may be excused if the party aggrieved shows by a preponderance of the evidence that he did not receive the notice of the determination and the forms necessary to appeal the determination. The claimant, employer or insurer shall notify the hearing officer of a change of address.

Sec. 13. NRS 616C.360 is hereby amended to read as follows:

616C.360 1. A stenographic or electronic record must be kept of the hearing before the appeals officer and the rules of evidence applicable to contested cases under chapter 233B of NRS apply to the hearing.

2. The appeals officer must hear any matter raised before him on its merits, including new evidence bearing on the matter.

3. If necessary to resolve a medical question concerning an injured employee's condition or to determine the necessity of treatment for which authorization for payment has been denied, the appeals officer ~~[may refer the employee to a physician or chiropractor of his choice who has demonstrated special competence to treat the particular medical condition of the employee. If the~~

~~medical question concerns the rating of a permanent disability, the appeals officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians or chiropractors maintained by the Administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor.~~] ***shall submit the matter to an external review organization in accordance with section 6 of this act and the regulations adopted by the Administrator.*** The insurer shall pay the costs of [~~any examination requested by~~] ***the external review. After the external review organization renders its decision on the matter, the decision is binding on*** the appeals officer.

4. If an injured employee has requested payment for the cost of obtaining a second determination of his percentage of disability pursuant to NRS 616C.100, the appeals officer shall decide whether the determination of the higher percentage of disability made pursuant to NRS 616C.100 is appropriate and, if so, may order the insurer to pay to the employee an amount equal to the maximum allowable fee established by the Administrator pursuant to NRS 616C.260 for the type of service performed, or the usual fee of that physician or chiropractor for such service, whichever is less.

5. The appeals officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

6. Any party to the appeal or the appeals officer may order a transcript of the record of the hearing at any time before the seventh day after the hearing. The transcript must be filed within 30 days after the date of the order unless the appeals officer otherwise orders.

7. The appeals officer shall render his decision:

(a) If a transcript is ordered within 7 days after the hearing, within 30 days after the transcript is filed; or

(b) If a transcript has not been ordered, within 30 days after the date of the hearing.

8. The appeals officer may affirm, modify or reverse any decision made by the hearing officer and issue any necessary and proper order to give effect to his decision.

Sec. 14. NRS 616C.390 is hereby amended to read as follows:

616C.390 1. If an application to reopen a claim to increase or rearrange compensation is made in writing more than 1 year after the date on which the claim was closed, the insurer shall reopen the claim if:

(a) A change of circumstances warrants an increase or rearrangement of compensation during the life of the claimant;

(b) The primary cause of the change of circumstances is the injury for which the claim was originally made; and

(c) The application is accompanied by the certificate of a physician or a chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation.

2. After a claim has been closed, the insurer, upon receiving an application and for good cause shown, may authorize the reopening of the claim for medical investigation only. The application must be accompanied by a written request for treatment from the physician or chiropractor treating the claimant, certifying that the treatment is indicated by a change in circumstances and is related to the industrial injury sustained by the claimant.

3. If a claimant applies for a claim to be reopened pursuant to subsection 1 or 2 and a final determination denying the reopening is issued, the claimant shall not reapply to reopen the claim until at least 1 year after the date on which the final determination is issued.

4. Except as otherwise provided in subsection 5, if an application to reopen a claim is made in writing within 1 year after the date on which the claim was closed, the insurer shall reopen the claim only if:

(a) The application is supported by medical evidence demonstrating an objective change in the medical condition of the claimant; and

(b) There is clear and convincing evidence that the primary cause of the change of circumstances is the injury for which the claim was originally made.

5. An application to reopen a claim must be made in writing within 1 year after the date on which the claim was closed if:

(a) The claimant was not off work as a result of the injury; and

(b) The claimant did not receive benefits for a permanent partial disability.

If an application to reopen a claim to increase or rearrange compensation is made pursuant to this subsection, the insurer shall reopen the claim if the requirements set forth in paragraphs (a), (b) and (c) of subsection 1 are met.

6. If an employee’s claim is reopened pursuant to this section, he is not entitled to vocational rehabilitation services or benefits for a temporary total disability if, before his claim was reopened, he:

(a) Retired; or

(b) Otherwise voluntarily removed himself from the workforce,

for reasons unrelated to the injury for which the claim was originally made.

7. One year after the date on which the claim was closed, an insurer may dispose of the file of a claim authorized to be reopened pursuant to subsection 5, unless an application to reopen the claim has been filed pursuant to that subsection.

8. An increase or rearrangement of compensation is not effective before an application for reopening a claim is made unless good cause is shown. The insurer shall, upon good cause shown, allow the cost of emergency treatment the necessity for which has been certified by a physician or a chiropractor.

9. A claim that closes pursuant to subsection 2 of NRS 616C.235 and is not appealed or is unsuccessfully appealed pursuant to the provisions of NRS 616C.305 and 616C.315 to 616C.385, inclusive, may not be reopened pursuant to this section.

~~[10. The provisions of this section apply to any claim for which an application to reopen the claim or to increase or rearrange compensation is made pursuant to this section, regardless of the date of the injury or accident to the claimant. If a claim is reopened pursuant to this section, the amount of any compensation or benefits provided must be determined in accordance with the provisions of NRS 616C.425.]~~

Sec. 15. NRS 695C.125 is hereby amended to read as follows:

695C.125 ***1.*** A health maintenance organization shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the health maintenance organization to its enrollees.

2. The provisions of this section do not apply to an administrative fee charged to a provider of health care pursuant to NRS 616B.5285.

Sec. 16. NRS 695G.270 is hereby amended to read as follows:

695G.270 ***1.*** A managed care organization that establishes a panel of providers of health care for the purpose of offering health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS shall not charge a provider of health care a fee to include the name of the provider on the panel of providers of health care.

2. The provisions of this section do not apply to an administrative fee charged to a provider of health care pursuant to NRS 616B.5285.

Sec. 17. 1. Notwithstanding the amendatory provisions of this act, an appeals officer shall not submit a matter for external review pursuant to NRS 616C.360, as amended by this act, until the Administrator has issued a certificate pursuant to section 3 of this act to at least one external review organization that is qualified to conduct an external review of the matter.

2. As used in this section, "Administrator" means the Administrator of the Division of Industrial Relations of the Department of Business and Industry.

Sec. 18. This act becomes effective upon passage and approval for the purpose of adopting regulations, and on October 1, 2003, for all other purposes.

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