VIRGINIA ACTS OF ASSEMBLY -- 2004 SESSION

CHAPTER 855

An Act to amend and reenact §§ 2.2-2818, 32.1-46, 32.1-50, 32.1-60, 32.1-64.1, 32.1-138, 32.1-325, 32.1-331.15, 45.1-161.35, 45.1-161.70, 45.1-161.292:43, 46.2-208, 46.2-322, 53.1-22, 54.1-3812, 59.1-297, 59.1-298, 59.1-310.4, and 63.2-1808 of the Code of Virginia, and to amend the Code of Virginia by adding a section numbered 54.1-2957.02, relating to licensed nurse practitioners.

[H 855]

Approved April 14, 2004

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 32.1-46, 32.1-50, 32.1-60, 32.1-64.1, 32.1-138, 32.1-325, 32.1-331.15, 45.1-161.35, 45.1-161.70, 45.1-161.292:43, 46.2-208, 46.2-322, 53.1-22, 54.1-3812, 59.1-297, 59.1-298, 59.1-310.4, and 63.2-1808 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 54.1-2957.02 as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age ~~thirty-five~~ *35* through ~~thirty-nine~~ *39*, one such mammogram biennially to persons age ~~forty~~ *40* through ~~forty-nine~~ *49*, and one such mammogram annually to persons age ~~fifty~~ *50* and over and may be limited to a benefit of ~~fifty~~ ~~dollars~~ *$50* per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization ~~physician~~ *provider*, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits that shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial health entities to review such decisions. Impartial health entities may include medical peer review organizations and independent utilization review companies. The Department shall adopt regulations to assure that the impartial health entity conducting the reviews has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final denial of claims to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

Prior to assigning an appeal to an impartial health entity, the Department shall verify that the impartial health entity conducting the review of a denial of claims has no relationship or association with (i) the covered employee, (ii) the treating health care provider, or any of its employees or affiliates, (iii) the medical care facility at which the covered service would be provided, or any of its employees or affiliates, or (iv) the development or manufacture of the drug, device, procedure or other therapy that is the subject of the final denial of a claim. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of his powers and duties.

5. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

6. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

7. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

8. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

9. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

12. Include coverage providing a minimum stay in the hospital of not less than ~~forty-eight~~ *48* hours for a patient following a radical or modified radical mastectomy and ~~twenty-four~~ *24* hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of

breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

13. Include coverage (i) to persons age ~~fifty~~ *50* and over and (ii) to persons age ~~forty~~ *40* and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a ~~twelve~~ *12*-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

14. Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may, after consultation with the primary care physician, receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the primary care provider, in consultation with the plan and the specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

15. Include provisions allowing employees to continue receiving health care services for a period of up to ~~ninety~~ *90* days from the date of the primary care physician's notice of termination from any of the plan's provider panels. The plan shall notify any provider at least ~~ninety~~ *90* days prior to the date of termination of the provider, except when the provider is terminated for cause.

For a period of at least ~~ninety~~ *90* days from the date of the notice of a provider's termination from any of the plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the plan to render health care services to any of the covered employees who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider.

Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of postpartum care directly related to the delivery.

Notwithstanding the provisions of subdivision 1, any provider shall be permitted to continue rendering health services to any covered employee who is determined to be terminally ill (as defined under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for the remainder of the employee's life for care directly related to the treatment of the terminal illness.

A provider who continues to render health care services pursuant to this subdivision shall be reimbursed in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

16. Include coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

For purposes of this subdivision:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

"FDA" means the Federal Food and Drug Administration.

"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient" means a person covered under the plan established pursuant to this section.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

a. The National Cancer Institute;

b. An NCI cooperative group or an NCI center;

c. The FDA in the form of an investigational new drug application;

d. The federal Department of Veterans Affairs; or

e. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

Coverage under this section shall apply only if:

(1) There is no clearly superior, noninvestigational treatment alternative;

(2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigatonal alternative; and

(3) The patient and the physician or health care provider who provides services to the patient under the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures established by the plan.

17. Include coverage providing a minimum stay in the hospital of not less than ~~twenty-three~~ *23* hours for a covered employee following a laparoscopy-assisted vaginal hysterectomy and ~~forty-eight~~ *48* hours for a covered employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines. Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is appropriate.

18. (Effective until July 1, 2004) Include coverage for biologically based mental illness.

For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

19. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age,

height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

20. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

21. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such corrective information as may be required to electronically process a prescription claim.

22. Include coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include follow-up audiological examinations as recommended by a physician, *nurse practitioner* or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and their beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Human Resource Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

G. The plan shall include, in each planning district, at least two health coverage options, each sponsored by unrelated entities. In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan. This section shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan

separate from the plan established by the Department.

H. Any self-insured group health insurance plan established by the Department of Personnel that includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and (iii) other health care providers.

If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a specific, medically necessary nonformulary prescription drug if, after reasonable investigation and consultation with the ~~prescribing~~ ~~physician~~ *prescriber*, the formulary drug is determined to be an inappropriate therapy for the medical condition of the person. The plan shall act on such requests within one business day of receipt of the request.

I. Any plan established in accordance with this section requiring preauthorization prior to rendering medical treatment shall have personnel available to provide authorization at all times when such preauthorization is required.

J. Any plan established in accordance with this section shall provide to all covered employees written notice of any benefit reductions during the contract period at least ~~thirty~~ *30* days before such reductions become effective.

K. No contract between a provider and any plan established in accordance with this section shall include provisions that require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a covered employee with similar medical conditions.

L. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect the interests of covered employees under any state employee's health plan.

The Ombudsman shall:

1. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.

2. Answer inquiries from covered employees by telephone and electronic mail.

3. Provide to covered employees information concerning the state health plans.

4. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.

5. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in subdivision 4 and such additional information as he deems appropriate.

6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

7. Upon request, assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

8. Ensure that covered employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

9. Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year.

M. The plan established in accordance with this section shall not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until the covered employee notifies the plan in writing of the assignment.

N. Any group health insurance plan established by the Department of Human Resource Management that contains a coordination of benefits provision shall provide written notification to any eligible employee as a prominent part of its enrollment materials that if such eligible employee is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the eligible employee. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered expenses of each family member.

O. Any plan established by the Department of Human Resource Management pursuant to this section shall provide that coverage under such plan for family members enrolled under a participating state employee's coverage shall continue for a period of at least ~~thirty~~ *30* days following the death of such state employee.

§ 32.1-46. Immunization of children against certain diseases; authority to share immunization records.

A. The parent, guardian or person standing in loco parentis of each child within this Commonwealth shall cause such child to be immunized by vaccine against diphtheria, tetanus, whooping cough and poliomyelitis before such child attains the age of one year, against Haemophilus influenzae type b before he attains the age of ~~thirty~~ *30* months, and against measles (rubeola), German measles (rubella) and mumps before such child attains the age of two years. All children born on or after January 1, 1994, shall be required to receive immunization against hepatitis B before their first birthday. All children shall also be required to receive a second dose of measles (rubeola) vaccine in accordance with the regulations of the Board. The Board's regulations shall require that all children receive a second dose of measles (rubeola) vaccine prior to first entering kindergarten or first grade and that all children who have not yet received a second dose of measles (rubeola) vaccine receive such second dose prior to entering the sixth grade. All children born on or after January 1, 1997, shall be required to receive immunization against varicella zoster (chicken pox), not earlier than the age of ~~twelve~~ *12* months. Children who have evidence of immunity as demonstrated by laboratory confirmation of immunity or a reliable medical history of disease are exempt from such requirement. After July 1, 2001, all children who have not yet received immunization against hepatitis B shall receive such immunization prior to entering sixth grade.

The parent, guardian or person standing in loco parentis may have such child immunized by a physician or registered nurse or may present the child to the appropriate local health department, which shall administer the required vaccines without charge.

B. A physician, registered nurse or local health department administering a vaccine required by this section shall provide to the person who presents the child for immunizations a certificate ~~which~~ *that* shall state the diseases for which the child has been immunized, the numbers of doses given, the dates when administered and any further immunizations indicated.

C. The vaccines required by this section shall meet the standards prescribed in, and be administered in accordance with, regulations of the Board.

D. The provisions of this section shall not apply if:

1. The parent or guardian of the child objects thereto on the grounds that the administration of immunizing agents conflicts with his religious tenets or practices, unless an emergency or epidemic of disease has been declared by the Board, or

2. The parent or guardian presents a statement from a physician licensed to practice medicine in Virginia ~~which~~, *or a licensed nurse practitioner, that* states that the physical condition of the child is such that the administration of one or more of the required immunizing agents would be detrimental to the health of the child.

E. For the purpose of protecting the public health by ensuring that each child receives age-appropriate immunizations, any physician, *nurse practitioner,* licensed institutional health care provider, local or district health department, and the Department of Health may share immunization and child locator information, including, but not limited to, the month, day, and year of each administered immunization; the child's name, address, telephone number, birth date, and social security number; and the parents' names. The immunization information; the child's name, address, telephone number, birth date, and social security number; and the parents' names shall be confidential and shall only be shared for the purposes set out in this subsection.

§ 32.1-50. Examination of persons suspected of having active tuberculosis disease; reporting; report forms; report schedule; laboratory reports and required samples.

A. Any local health director may request any person having or reasonably suspected of having active tuberculosis disease to be examined immediately for the purpose of ascertaining the presence or absence of the disease. Such examination may be made by any licensed physician *or licensed nurse practitioner* selected by such person at his own expense and approved by the local health director or by the local health director at no cost to such person.

B. Each physician *or nurse practitioner* practicing in the Commonwealth who diagnoses or treats a person for active tuberculosis disease as defined in § 32.1-49.1 and each person in charge of a medical care facility providing inpatient or outpatient diagnosis or treatment for active tuberculosis disease shall report to the local health director within such time period and in such manner as may be prescribed by regulations of the Board. Such report, at a minimum, shall include an initial report when there are reasonable grounds to believe that a person has active tuberculosis disease, and a subsequent report when a person ceases treatment for tuberculosis disease. Cessation of treatment may be inferred when the person (i) fails to keep a scheduled appointment, (ii) relocates without transferring care, or (iii) discontinues care either upon or against the advice of the treating physician *or nurse practitioner*.

C. The initial disease report shall include the following: the affected person's name; date of birth; gender; address; pertinent clinical, radiographic, microbiologic, and pathologic reports, whether final or

pending; such other information as is needed to locate the patient for follow-up; and any other information as prescribed by regulations of the Board.

D. Subsequent reports shall be submitted within such time, at such frequency, and in such manner as may be prescribed by regulations of the Board and shall provide updated clinical status, bacteriologic and radiographic results, assessment of treatment adherence, name of current care provider, and any other information as prescribed by the Board.

E. Every director of any laboratory doing business in the Commonwealth shall, according to the manner and schedule as determined by the Board, report any result diagnostic of or highly correlated with active tuberculosis disease, whether testing is done in-house or referred to an out-of-state laboratory, including cultures positive for tubercle bacilli and smears suggestive of tubercle bacilli, and shall report the results of tests for antimicrobial susceptibility performed on cultures positive for tubercle bacilli. Each director of any laboratory shall also submit a representative and viable sample of the initial culture to the Virginia Division of Consolidated Laboratory Services or other laboratory designated by the Board to receive such specimen in order to ensure testing for antimicrobial susceptibility on each initial isolate from a person with active tuberculosis disease; however, this requirement may be fulfilled by submission to the local health director of a report of antimicrobial drug susceptibilities performed by a laboratory certified by existing state or national agencies to perform such testing. The intention to file a written report shall be communicated to the local health director at the time the finding of a culture positive for tubercle bacilli is initially reported.

§ 32.1-60. Prenatal tests required.

Every physician *or nurse practitioner* attending a pregnant woman during gestation shall examine and test such woman for such venereal diseases as the Board may designate within ~~fifteen~~ *15* days after beginning such attendance. Every other person permitted by law to attend upon pregnant women but not permitted by law to make such examinations and tests, shall cause such examinations and tests to be made by a licensed physician, *licensed nurse practitioner,* or clinic. Serological tests required by this section may be performed by the Department of General Services, Division of Consolidated Laboratory Services (DCLS).

§ 32.1-64.1. Virginia Hearing Impairment Identification and Monitoring System.

A. In order to identify hearing loss at the earliest possible age among newborns and to provide early intervention for all infants so identified as having hearing impairment, the Commissioner shall establish and maintain the Virginia Hearing Impairment Identification and Monitoring System. This system shall be for the purpose of identifying and monitoring infants with hearing impairment to ensure that such infants receive appropriate early intervention through treatment, therapy, training and education.

B. The Virginia Hearing Impairment Identification and Monitoring System shall be initiated in all hospitals with neonatal intensive care services, in all hospitals in the Commonwealth having newborn nurseries, and in other birthing places or centers in the Commonwealth having newborn nurseries.

C. In all hospitals with neonatal intensive care services, the chief medical officer of such hospitals or his designee shall identify infants at risk of hearing impairment using criteria established by the Board. Beginning on July 1, 1999, all infants shall be given a hearing screening test, regardless of whether or not the infant is at risk of hearing impairment, by the chief medical officer or his designee using methodology approved by the Board. The test shall take place before the infant is discharged from the hospital to the care of the parent or guardian, or as the Board may by regulation provide.

In all other hospitals and other birthing places or centers, the chief medical officer or his designee or the attending practitioner shall identify infants at risk of hearing impairment using criteria established by the Board.

D. Beginning on July 1, 2000, the Board shall provide by regulation for the giving of hearing screening tests for all infants born in all hospitals. The Board's regulations shall establish when the testing shall be offered and performed and procedures for reporting.

An infant whose hearing screening indicates the need for a diagnostic audiological examination shall be offered such examination at a center approved by the Board of Health. As a condition of such approval, such centers shall maintain suitable audiological support and medical and educational referral practices.

E. The Commissioner shall appoint an advisory committee to assist in the design, implementation, and revision of this identification and monitoring system. The advisory committee shall meet at least four times per year. A chairman shall be elected annually by the advisory committee. The Department of Health shall provide support services to the advisory committee. The advisory committee shall consist of representatives from relevant groups including, but not limited to, the health insurance industry; physicians, including at least one pediatrician or family practitioner, one otolaryngologist, and one neonatologist; nurses representing newborn nurseries; audiologists; hearing aid dealers and fitters; teachers of the deaf and hard-of-hearing; parents of children who are deaf or hard-of-hearing; adults who are deaf or hard-of-hearing; hospital administrators; and personnel of appropriate state agencies, including the Department of Medical Assistance Services, the Department of Education, and the Department for the Deaf and Hard-of-Hearing. The Department of Education, the Department for the Deaf and Hard-of-Hearing, and the Department of Mental Health, Mental Retardation and Substance

Abuse Services shall cooperate with the Commissioner and the Board in implementing this system.

F. With the assistance of the advisory committee, the Board shall promulgate such rules and regulations as may be necessary to implement this identification and monitoring system. These rules and regulations shall include criteria, including current screening methodology, for the identification of infants (i) with hearing impairment and (ii) at risk of hearing impairment and shall include the scope of the information to be reported, reporting forms, screening protocols, appropriate mechanisms for follow-up, relationships between the identification and monitoring system and other state agency programs or activities and mechanisms for review and evaluation of the activities of the system. The identification and monitoring system shall collect the name, address, sex, race, and any other information determined to be pertinent by the Board, regarding infants determined to be at risk of hearing impairment or to have hearing loss.

G. In addition, the Board's regulations shall provide that any person making a determination that an infant (i) is at risk for hearing impairment, (ii) has failed to pass a hearing screening, or (iii) was not successfully tested shall notify the parent or guardian of the infant, the infant's primary care ~~physician~~ *practitioner*, and the Commissioner.

H. No testing required to be performed or offered by this section shall be performed if the parents of the infant object to the test based on their bona fide religious convictions.

§ 32.1-138. Enumeration; posting of policies; staff training; responsibilities devolving on guardians, etc.; exceptions; certification of compliance.

A. The governing body of a nursing home facility required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter, through the administrator of such facility, shall cause to be promulgated policies and procedures to ensure that, at the minimum, each patient admitted to such facility:

1. Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during his stay, of his rights and of all rules and regulations governing patient conduct and responsibilities;

2. Is fully informed, prior to or at the time of admission and during his stay, of services available in the facility and of related charges, including any charges for services not covered under Titles XVIII or XIX of the United States Social Security Act or not covered by the facility's basic per diem rate;

3. Is fully informed in summary form of the findings concerning the facility in federal Health Care Financing Administration surveys and investigations, if any;

4. Is fully informed by a physician *or nurse practitioner* of his medical condition unless medically contraindicated as documented by a physician *or nurse practitioner* in his medical record and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

5. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act, and is given reasonable advance notice as provided in § 32.1-138.1 to ensure orderly transfer or discharge, and such actions are documented in his medical record;

6. Is encouraged and assisted, throughout the period of his stay, to exercise his rights as a patient and as a citizen and to this end may voice grievances and recommend changes in policies and services to facility staff and to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

7. May manage his personal financial affairs, or may have access to records of financial transactions made on his behalf at least once a month and is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with state law;

8. Is free from mental and physical abuse and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician for a specified and limited period of time or when necessary to protect the patient from injury to himself or to others;

9. Is assured confidential treatment of his personal and medical records and may approve or refuse their release to any individual outside the facility, except in case of his transfer to another health care institution or as required by law or third-party payment contract;

10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. May associate and communicate privately with persons of his choice and send and receive his personal mail unopened, unless medically contraindicated as documented by his physician in his medical record;

13. May meet with and participate in activities of social, religious and community groups at his discretion, unless medically contraindicated as documented by his physician *or nurse practitioner* in his medical record;

14. May retain and use his personal clothing and possessions as space permits unless to do so would

infringe upon rights of other patients and unless medically contraindicated as documented by his physician *or nurse practitioner* in his medical record; and

15. If married, is assured privacy for visits by his or her spouse and if both are inpatients in the facility, is permitted to share a room with such spouse unless medically contraindicated as documented by the attending physician *or nurse practitioner* in the medical record.

B. All established policies and procedures regarding the rights and responsibilities of patients shall be printed in at least ~~twelve~~ *12*-point type and posted conspicuously in a public place in all nursing home facilities required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter. These policies and procedures shall include the name and telephone number of the complaint coordinator in the Division of Licensure and Certification of the Virginia Department of Health, the Adult Protective Services' toll-free telephone number, as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program and any substate ombudsman program serving the area. Copies of such policies and procedures shall be given to patients upon admittance to the facility and made available to patients currently in residence, to any guardians, next of kin, or sponsoring agency or agencies, and to the public.

C. The provisions of this section shall not be construed to restrict any right ~~which~~ *that* any patient in residence has under law.

D. Each facility shall provide appropriate staff training to implement each patient's rights included in subsection A hereof.

E. All rights and responsibilities specified in subsection A hereof and § 32.1-138.1 as they pertain to (i) a patient adjudicated incapacitated in accordance with state law, (ii) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (iii) a patient who is unable to communicate with others shall devolve to such patient's guardian, next of kin, sponsoring agency or agencies, or representative payee, except when the facility itself is representative payee, selected pursuant to section 205(j) of Title II of the United States Social Security Act.

F. Nothing in this section shall be construed to prescribe, regulate, or control the remedial care and treatment or nursing service provided to any patient in a nursing institution to which the provisions of § 32.1-128 are applicable.

G. It shall be the responsibility of the Commissioner to insure that the provisions of this section and the provisions of § 32.1-138.1 are observed and implemented by nursing home facilities. Each nursing home facility to which this section and § 32.1-138.1 are applicable shall certify to the Commissioner that it is in compliance with the provisions of this section and the provisions of § 32.1-138.1 as a condition to the issuance or renewal of the license required by Article 1 (§ 32.1-123 et seq.) of this chapter.

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician *or nurse practitioner* and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of

Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician, *nurse practitioner,* or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;

22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women; and

23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for both programs.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the

Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments ~~which~~ *that* are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider ~~which~~ *who* has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of 18 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in ~~subsection~~ *subdivision* A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-331.15. Prior authorization of prescription drug products; coverage under state plan.

A. The Committee shall review prescription drug products to recommend prior authorization under the state plan in accordance with this article and regulations promulgated by the Board. Such review

may be initiated by the Director, the Committee itself, or by written request of the Board. The Committee shall complete its recommendations to the Board within no more than six months from receipt of any such request.

B. Coverage under the state plan for any drug requiring prior authorization shall not be approved unless ~~a prescribing physician~~ *the prescriber* obtains prior approval of such use in accordance with regulations promulgated by the Board and procedures established by the Department.

In formulating its recommendations to the Board, the Committee shall consider the potential impact on patient care and the potential fiscal impact of prior authorization on pharmacy, ~~physician~~ *prescriber*, hospitalization and outpatient costs. Any proposed regulation making a drug or category of drugs subject to prior authorization shall be accompanied by a statement of the estimated impact of such action on pharmacy, ~~physician~~ *prescriber*, hospitalization and outpatient costs.

C. The Committee shall not review any drug for which it has recommended or the Board has required prior authorization within the previous ~~twelve~~ *12* months, unless new or previously unavailable relevant and objective information is presented.

D. Confidential proprietary information identified as such by a manufacturer or supplier in writing in advance and furnished to the Committee or the Board pursuant to this article shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). The Board shall establish by regulation the means by which such confidential proprietary information shall be protected.

§ 45.1-161.35. Revocation of certificates.

A. The Board of Coal Mining Examiners may revoke any certificate upon finding that the holder has (i) failed to comply with the continuing education requirements within the period following the suspension of the certificate as provided in § 45.1-161.34; (ii) been intoxicated while in duty status; (iii) neglected his duties; (iv) violated any provision of this Act or any other coal mining law of the Commonwealth; (v) used any controlled substance without the prescription of a licensed ~~physician~~ *prescriber*; or (vi) other sufficient cause. The Board shall also revoke the first class mine foreman certificate of any mine foreman who fails to display a thorough understanding of the roof control plan and ventilation for the area of the mine for which he is responsible for implementing, when examined on-site by a mine inspector in accordance with guidelines promulgated by the Board. In such a case, the Board shall make a determination, based on evidence presented by interested parties, of whether the mine foreman had a thorough knowledge of such plans at the time of his examination by the mine inspector.

B. The Board may act to revoke any certificate upon the presentation of written charges by (i) the Chief or the Director or his designated agent; (ii) the operator of a mine at which such person is employed; or (iii) ten persons employed at the mine at which such person is employed, or, if less than ten persons are employed at the mine, a majority of the employees at the mine. The Board may act on its own initiative to revoke any certificate for grounds set forth in item (i) of subsection A.

C. An affirmative vote of a majority of members of the Board who are qualified to vote shall be required for any action to revoke a certificate.

D. Prior to revoking a certificate, the Board shall give due notice to the holder of the certificate and conduct a hearing. Any hearing shall be conducted in accordance with § 2.2-4020 unless the parties agree to informal proceedings. The hearing may be conducted by the Board or, in the Board's discretion, by a hearing officer as provided in § 2.2-4025 et seq.

E. Any person who has been aggrieved by a decision of the Board shall be entitled to judicial review of such decision. Appeals from such decisions shall be in accordance with Article 5 (§ 2.2-4025 et seq.) of the Administrative Process Act.

§ 45.1-161.70. Qualification for crew membership; direction of crews.

A. To qualify for membership in mine rescue crews an applicant shall be an experienced miner and shall pass a physical examination by a licensed physician *or licensed nurse practitioner* at least annually. A record that such examination was taken shall be kept on file by the operator who employs the crew members and a copy shall be furnished to the Director.

B. All rescue or recovery work performed by these crews shall be under the jurisdiction of the Department. The Department shall consult with company officials, representatives of the Mine Safety and Health Administration and representatives of the miners, and all should be in agreement as far as possible on the proper procedure for rescue and recovery; however, the Chief in his discretion may take full responsibility in directing such work. Procedures for use of apparatus or equipment shall be guided by the mine rescue apparatus and auxiliary equipment manuals.

§ 45.1-161.292:43. Qualification for crew membership; direction of crews.

A. To qualify for membership in mine rescue crews, an applicant shall (i) be an experienced miner, (ii) be not more than ~~fifty~~ *50* years of age, and (iii) pass a physical examination by a licensed physician *or licensed nurse practitioner* at least annually. A record that such examination was taken shall be kept on file by the operator who employs the crew members and a copy shall be furnished to the Director.

B. All rescue or recovery work performed by these crews shall be under the jurisdiction of the Department. The Department shall consult with company officials, representatives of the Mine Safety

and Health Administration and representatives of the miners, and all should be in agreement as far as possible on the proper procedure for rescue and recovery; however, the Director in his discretion may take full responsibility in directing such work. In all instances, procedures shall be guided by the mine rescue apparatus and auxiliary equipment manuals.

§ 46.2-208. Records of Department; when open for inspection; release of privileged information.

A. All records in the office of the Department containing the specific classes of information outlined below shall be considered privileged records:

1. Personal information, including all data defined as "personal information" in § 2.2-3801;

2. Driver information, including all data that relates to driver's license status and driver activity; and

3. Vehicle information, including all descriptive vehicle data and title, registration, and vehicle activity data.

B. The Commissioner shall release such information only under the following conditions:

1. Notwithstanding other provisions of this section, medical data included in personal data shall be released only to a physician *or nurse practitioner* as provided in § 46.2-322.

2. Insurance data may be released as specified in §§ 46.2-372, 46.2-380, and 46.2-706.

3. Notwithstanding other provisions of this section, information disclosed or furnished shall be assessed a fee as specified in § 46.2-214.

4. When the person requesting the information is (i) the subject of the information, (ii) the parent or guardian of the subject of the information, (iii) the authorized representative of the subject of the information, or (iv) the owner of the vehicle that is the subject of the information, the Commissioner shall provide him with the requested information and a complete explanation of it. Requests for such information need not be made in writing or in person and may be made orally or by telephone, provided that the Department is satisfied that there is adequate verification of the requester's identity. When so requested in writing by (a) the subject of the information, (b) the parent or guardian of the subject of the information, (c) the authorized representative of the subject of the information, or (d) the owner of the vehicle that is the subject of the information, the Commissioner shall verify and, if necessary, correct the personal information provided and furnish driver and vehicle information in the form of an abstract of the record.

5. On the written request of any insurance carrier, surety, or representative of an insurance carrier or surety, the Commissioner shall furnish such insurance carrier, surety, or representative an abstract of the record of any person subject to the provisions of this title. The abstract shall include any record of any conviction of a violation of any provision of any statute or ordinance relating to the operation or ownership of a motor vehicle or of any injury or damage in which he was involved and a report of which is required by § 46.2-372. No such report of any conviction or accident shall be made after 60 months from the date of the conviction or accident unless the Commissioner or court used the conviction or accident as a reason for the suspension or revocation of a driver's license or driving privilege, in which case the revocation or suspension and any conviction or accident pertaining thereto shall not be reported after 60 months from the date that the driver's license or driving privilege has been reinstated. This abstract shall not be admissible in evidence in any court proceedings.

6. On the written request of any business organization or its agent, in the conduct of its business, the Commissioner shall compare personal information supplied by the business organization or agent with that contained in the Department's records and, when the information supplied by the business organization or agent is different from that contained in the Department's records, provide the business organization or agent with correct information as contained in the Department's records. Personal information provided under this subdivision shall be used solely for the purpose of pursuing remedies that require locating an individual.

7. The Commissioner shall provide vehicle information to any business organization or agent on such business' or agent's written request. Disclosures made under this subdivision shall not include any personal information and shall not be subject to the limitations contained in subdivision 6 of this subsection.

8. On the written request of any motor vehicle rental or leasing company or its designated agent, the Commissioner shall (i) compare personal information supplied by the company or agent with that contained in the Department's records and, when the information supplied by the company or agent is different from that contained in the Department's records, provide the company or agent with correct information as contained in the Department's records and (ii) provide the company or agent with driver information in the form of an abstract of any person subject to the provisions of this title. Such abstract shall include any record of any conviction of a violation of any provision of any statute or ordinance relating to the operation or ownership of a motor vehicle or of any injury or damage in which the subject of the abstract was involved and a report of which is required by § 46.2-372. No such abstract shall include any record of any conviction or accident more than 60 months after the date of such conviction or accident unless the Commissioner or court used the conviction or accident as a reason for the suspension or revocation of a driver's license or driving privilege, in which case the revocation or suspension and any conviction or accident pertaining thereto shall cease to be included in such abstract after 60 months from the date on which the driver's license or driving privilege was reinstated. No

abstract released under this subdivision shall be admissible in evidence in any court proceedings.

9. On the request of any federal, state, or local governmental entity, law-enforcement officer, attorney for the Commonwealth, court, or the authorized agent of any of the foregoing, the Commissioner shall (i) compare personal information supplied by the governmental entity, officer, attorney for the Commonwealth, court, or the authorized agent of any of the foregoing, with that contained in the Department's records and, when the information supplied by the governmental entity, officer, attorney for the Commonwealth, court, or the authorized agent of any of the foregoing, is different from that contained in the Department's records, provide the governmental entity, officer, attorney for the Commonwealth, court, or the authorized agent of any of the foregoing, with correct information as contained in the Department's records and (ii) provide driver and vehicle information in the form of an abstract of the record showing all convictions, accidents, driver's license suspensions or revocations, and other appropriate information as the governmental entity, officer, attorney for the Commonwealth, court, or the authorized agent of any of the foregoing, may require in order to carry out its official functions.

10. On request of the driver licensing authority in any other state or foreign country, the Commissioner shall provide whatever classes of information the requesting authority shall require in order to carry out its official functions.

11. On the written request of any employer, prospective employer, or authorized agent of either, and with the written consent of the individual concerned, the Commissioner shall (i) compare personal information supplied by the employer, prospective employer, or agent with that contained in the Department's records and, when the information supplied by the employer, prospective employer, or agent is different from that contained in the Department's records, provide the employer, prospective employer, or agent with correct information as contained in the Department's records and (ii) provide the employer, prospective employer, or agent with driver information in the form of an abstract of an individual's record showing all convictions, accidents, driver's license suspensions or revocations, and any type of driver's license that the individual currently possesses, provided that the individual's position or the position that the individual is being considered for involves the operation of a motor vehicle.

12. On the written request of any member of or applicant for membership in a volunteer fire company or volunteer rescue squad, the Commissioner shall (i) compare personal information supplied by the volunteer fire company or volunteer rescue squad with that contained in the Department's records and, when the information supplied by the volunteer fire company or volunteer rescue squad is different from that contained in the Department's records, provide the volunteer fire company or volunteer rescue squad with correct information as contained in the Department's records and (ii) provide driver information in the form of an abstract of the member's or applicant's record showing all convictions, accidents, license suspensions or revocations, and any type of driver's license that the individual currently possesses. Such abstract shall be provided free of charge if the request is accompanied by appropriate written evidence that the person is a member of or applicant for membership in a volunteer fire company or volunteer rescue squad and the abstract is needed by a volunteer fire company or volunteer rescue squad to establish the qualifications of the member or applicant to operate equipment owned by the volunteer fire company or volunteer rescue squad.

13. On the written request of any person who has applied to be a volunteer with a Virginia affiliate of Big Brothers/Big Sisters of America, the Commissioner shall (i) compare personal information supplied by a Virginia affiliate of Big Brothers/Big Sisters of America with that contained in the Department's records and, when the information supplied by a Virginia affiliate of Big Brothers/Big Sisters of America is different from that contained in the Department's records, provide the Virginia affiliate of Big Brothers/Big Sisters of America with correct information as contained in the Department's records and (ii) provide driver information in the form of an abstract of the applicant's record showing all convictions, accidents, license suspensions or revocations, and any type of driver's license that the individual currently possesses. Such abstract shall be provided free of charge if the request is accompanied by appropriate written evidence that the person has applied to be a volunteer with a Virginia affiliate of Big Brothers/Big Sisters of America.

14. On the written request of any person who has applied to be a volunteer with a court-appointed special advocate program pursuant to § 9.1-153, the Commissioner shall provide an abstract of the applicant's record showing all convictions, accidents, license suspensions or revocations, and any type of driver's license that the individual currently possesses. Such abstract shall be provided free of charge if the request is accompanied by appropriate written evidence that the person has applied to be a volunteer with a court-appointed special advocate program pursuant to § 9.1-153.

15. Upon the request of any employer, prospective employer, or authorized representative of either, the Commissioner shall (i) compare personal information supplied by the employer, prospective employer, or agent with that contained in the Department's records and, when the information supplied by the employer, prospective employer, or agent is different from that contained in the Department's records, provide the employer, prospective employer, or agent with correct information as contained in the Department's records and (ii) provide driver information in the form of an abstract of the driving record of any individual who has been issued a commercial driver's license, provided that the individual's position or the position that the individual is being considered for involves the operation of

a commercial motor vehicle. Such abstract shall show all convictions, accidents, license suspensions, revocations, or disqualifications, and any type of driver's license that the individual currently possesses.

16. Upon the receipt of a completed application and payment of applicable processing fees, the Commissioner may enter into an agreement with any governmental authority or business to exchange information specified in this section by electronic or other means.

17. Upon the request of an attorney representing a person in a motor vehicle accident, the Commissioner shall provide vehicle information, including the owner's name and address, to the attorney.

18. Upon the request, in the course of business, of any authorized representative of an insurance company or of any not-for-profit entity organized to prevent and detect insurance fraud, the Commissioner shall provide all vehicle information, including the owner's name and address, descriptive data and title, registration, and vehicle activity data to such person.

19. Upon the request of an officer authorized to issue criminal warrants, for the purpose of issuing a warrant for arrest for unlawful disposal of trash or refuse in violation of § 33.1-346, the Commissioner shall provide vehicle information, including the owner's name and address.

20. Upon written request of the compliance agent of a private security services business, as defined in § 9.1-138, which is licensed by the Department of Criminal Justice Services, the Commissioner shall provide the name and address of the owner of the vehicle under procedures determined by the Commissioner.

21. Upon the request of the operator of a toll facility, or an authorized agent or employee of a toll facility operator, for the purpose of obtaining vehicle owner data under subsection I of § 46.2-819.1.

22. On the written request of any person who has applied to be a volunteer with a Virginia affiliate of Compeer, the Commissioner shall (i) compare personal information supplied by a Virginia affiliate of Compeer with that contained in the Department's records and, when the information supplied by a Virginia affiliate of Compeer is different from that contained in the Department's records, provide the Virginia affiliate of Compeer with correct information as contained in the Department's records and (ii) provide driver information in the form of an abstract of the applicant's record showing all convictions, accidents, license suspensions or revocations, and any type of driver's license that the individual currently possesses. Such abstract shall be provided free of charge if the request is accompanied by appropriate written evidence that the person has applied to be a volunteer with a Virginia affiliate of Compeer.

23. Upon the request of the Department of Environmental Quality for the purpose of obtaining vehicle owner data in connection with enforcement actions involving on-road testing of motor vehicles, pursuant to § 46.2-1178.1.

C. Whenever the Commissioner issues an order to suspend or revoke the driver's license or driving privilege of any individual, he may notify the National Driver Register Service operated by the United States Department of Transportation and any similar national driver information system and provide whatever classes of information the authority may require.

D. Accident reports may be inspected under the provisions of §§ 46.2-379 and 46.2-380.

E. Whenever the Commissioner takes any licensing action pursuant to the provisions of the Virginia Commercial Driver's License Act (§ 46.2-341.1 et seq.), he may provide information to the Commercial Driver License Information System, or any similar national commercial driver information system, regarding such action.

F. In addition to the foregoing provisions of this section, vehicle information may also be inspected under the provisions of §§ 43-33, 43-34, 46.2-633, and 46.2-1200.1 through 46.2-1237.

G. The Department may promulgate regulations to govern the means by which personal, vehicle, and driver information is requested and disseminated.

H. Driving records of any person accused of an offense involving the operation of a motor vehicle shall be provided by the Commissioner upon request to any person acting as counsel for the accused. If such counsel is from the public defender's office or has been appointed by the court, such records shall be provided free of charge.

I. The Department shall maintain the records of persons convicted of violations of subsection B of § 29.1-738, and §§ 29.1-738.02, 29.1-738.2, and 29.1-738.4 which shall be forwarded by every general district court or circuit court or the clerk thereof, pursuant to § 46.2-383. Such records shall be electronically available to any law-enforcement officer as provided for under clause (ii) of subdivision B 9.

§ 46.2-322. Examination of licensee believed incompetent; suspension, or restriction of license; license application to include questions as to physical or mental conditions of applicant; false answers; examination of applicant; physician's or nurse practitioner's statement.

A. If the Department has good cause to believe that a driver is incapacitated and therefore unable to drive a motor vehicle safely, after written notice of at least ~~fifteen~~ *15* days to the person, it may require him to submit to an examination to determine his fitness to drive a motor vehicle. If the driver so requests in writing, the Department shall give the Department's reasons for the examination, including the identity of all persons who have supplied information to the Department regarding the driver's fitness

to drive a motor vehicle. However, the Department shall not supply the reasons or information if its source is a relative of the driver or a physician *or nurse practitioner* treating the driver.

B. As a part of its examination, the Department may require a physical examination by a licensed physician *or licensed nurse practitioner* and a report on the results thereof. When it has completed its examination, the Department shall take whatever action may be appropriate and may suspend the license or privilege to drive a motor vehicle in the Commonwealth of the person or permit him to retain his license or privilege to drive a motor vehicle in the Commonwealth, or may issue a license subject to the restrictions authorized by § 46.2-329. Refusal or neglect of the person to submit to the examination or comply with restrictions imposed by the Department shall be grounds for suspension of his license or privilege to drive a motor vehicle in the Commonwealth.

C. The Commissioner shall include, as a part of the application for an original driver's license, or renewal thereof, questions as to the existence of physical or mental conditions ~~which~~ *that* impair the ability of the applicant to drive a motor vehicle safely. Any person knowingly giving a false answer to any such question shall be guilty of a Class 2 misdemeanor. If the answer to any such question indicates the existence of such condition, the Commissioner shall require an examination of the applicant by a licensed physician *or licensed nurse practitioner* as a prerequisite to the issuance of the driver's license. The report of the examination shall contain a statement that, in the opinion of the physician *or nurse practitioner*, the applicant's physical or mental condition at the time of the examination does or does not preclude his safe driving of motor vehicles.

§ 53.1-22. Misdemeanant suspected of having contagious disease.

Whenever any court shall have reason to believe that a person convicted by it of a misdemeanor who is sentenced to serve time in a local correctional facility is afflicted with any contagious or infectious disease dangerous to the public health, the court shall have such person examined by a licensed physician *or licensed nurse practitioner*. If the examination reveals the person is afflicted with such disease, the court may commit the person directly to the Department.

§ 54.1-2957.02. When nurse practitioner signature accepted.

Whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a nurse practitioner.

§ 54.1-3812. Release of records.

A. A veterinarian licensed by the Board shall release or authorize the release of rabies immunization records and other relevant treatment data of an animal under his care to a requesting physician *or nurse practitioner* who is contemplating the administration of the rabies treatment protocol to any person under his care who has been the victim of a bite or traumatic injury to the skin or body from such animal.

B. Any veterinarian licensed by the Board who in good faith releases or authorizes the release of an animal's rabies immunization records and other relevant data pursuant to this section shall not be liable for civil damages resulting from the release of such information.

§ 59.1-297. Right of cancellation.

A. Every health spa contract for the sale of health spa services may be cancelled under the following circumstances:

1. A buyer may cancel the contract without penalty within three business days of its making and, upon notice to the health spa of the buyer's intent to cancel, shall be entitled to receive a refund of all moneys paid under the contract.

2. A buyer may cancel the contract if the health spa relocates or goes out of business and fails to provide comparable alternate facilities within five driving miles of the location designated in the health spa contract. Upon receipt of notice of the buyer's intent to cancel, the health spa shall refund to the buyer funds paid or accepted in payment of the contract in an amount computed as prescribed in § 59.1-297.1.

3. The contract may be cancelled if the buyer dies or becomes physically unable to use a substantial portion of the services for 30 or more consecutive days. If the buyer becomes physically unable to use a substantial portion of the services for 30 or more consecutive days and wishes to cancel his contract, he must provide the health spa with a signed statement from his doctor *or nurse practitioner* verifying that he is physically unable to use a substantial portion of the health spa services for 30 or more consecutive days. Upon receipt of notice of the buyer's intent to cancel, the health spa shall refund to the buyer funds paid or accepted in payment of the contract in an amount computed as prescribed in § 59.1-297.1. In the case of disability, the health spa may require the buyer to submit to a physical examination by a doctor *or nurse practitioner* agreeable to the buyer and the health spa within 30 days of receipt of notice of the buyer's intent to cancel. The cost of the examination shall be borne by the health spa.

B. The buyer shall notify the health spa of cancellation in writing, by certified mail, return receipt requested, or personal delivery, to the address of the health spa as specified in the health spa contract.

C. If the customer has executed any credit or lien agreement with the health spa or its representatives or agents to pay for all or part of health spa services, any such negotiable instrument executed by the buyer shall be returned to the buyer within 30 days after such cancellation.

D. If the spa agrees to allow a consumer to cancel for any other reason not outlined in this section,

upon, receipt of notice of cancellation by the buyer, the health spa shall refund to the buyer funds paid or accepted in payment of the contract in an amount computed as prescribed in § 59.1-297.1.

§ 59.1-298. Notice to buyer.

A copy of the executed health spa contract shall be delivered to the buyer at the time the contract is executed. All health spa contracts shall (i) be in writing, (ii) be signed by the buyer, (iii) designate the date on which the buyer actually signed the contract, (iv) state the starting and expiration dates of the initial membership period, (v) separately identify any initiation fee, (vi) either in the contract itself or in a separate notice provided to the buyer at the time the contract is executed, notify each buyer that the buyer should attempt to resolve with the health spa any complaint the buyer has with the health spa, and that the Virginia Department of Agriculture and Consumer Services, Office of Consumer Affairs regulates health spas in the Commonwealth pursuant to the provisions of the Virginia Health Spa Act, and (vii) contain the provisions set forth in § 59.1-297 under a conspicuous caption: "BUYER'S RIGHT TO CANCEL" that shall read substantially as follows:

If you wish to cancel this contract, you may cancel by making or delivering written notice to this health spa. The notice must say that you do not wish to be bound by the contract and must be delivered or mailed before midnight of the third business day after you sign this contract. The notice must be delivered or mailed to: .....

(Health spa shall insert its name and mailing address.)

If canceled within three business days, you will be entitled to a refund of all moneys paid. You may also cancel this contract if this spa goes out of business or relocates and fails to provide comparable alternate facilities within five driving miles of the location designated in this contract. You may also cancel if you become physically unable to use a substantial portion of the health spa services for 30 or more consecutive days, and your estate may cancel in the event of your death. You must prove you are unable to use a substantial portion of the health spa services by a doctor's *or nurse practitioner's* certificate, and the health spa may also require that you submit to a physical examination, within 30 days of the notice of cancellation, by a doctor *or nurse practitioner* agreeable to you and the health spa. If you cancel after the three business days, the health spa may retain or collect a portion of the contract price equal to the proportionate value of the services or use of facilities you have already received. Any refund due to you shall be paid within 30 days of the effective date of cancellation.

§ 59.1-310.4. Warning signs.

A. A tanning facility shall post a warning sign in a conspicuous location where it is readily readable by persons entering the establishment. The sign shall contain the following warning:

DANGER: ULTRAVIOLET RADIATION

Repeated exposure to ultraviolet radiation may cause chronic sun damage to the skin characterized by wrinkling, dryness, fragility, and bruising of the skin, and skin cancer.

Failure to use protective eyewear may result in severe burns or permanent injury to the eyes.

Medications or cosmetics may increase your sensitivity to ultraviolet radiation. Consult a physician *or nurse practitioner* before using a sunlamp if you are using medications, have a history of skin problems, or believe you are especially sensitive to sunlight. Pregnant women or women taking oral contraceptives who use this product may develop discolored skin.
IF YOU DO NOT TAN IN THE SUN, YOU WILL NOT TAN FROM USE OF AN ULTRAVIOLET SUNLAMP.

B. A tanning facility shall post a warning sign, one sign for each tanning device, in a conspicuous location that is readily readable to a person about to use the device. The sign shall contain the following:

DANGER: ULTRAVIOLET RADIATION

1. Follow the manufacturer's instructions for use of this device.

2. Avoid too frequent or lengthy exposure. As with natural sunlight, exposure can cause serious eye and skin injuries and allergic reactions. Repeated exposure may cause skin cancer.

3. Wear protective eyewear. Failure to use protective eyewear may result in severe burns or permanent damage to the eyes.

4. Do not sunbathe before or after exposure to ultraviolet radiation from sunlamps.

5. Medications or cosmetics may increase your sensitivity to ultraviolet radiation. Consult a physician *or nurse practitioner* before using a sunlamp if you are using medication, have a history of skin problems, or believe you are especially sensitive to sunlight. Pregnant women or women using oral contraceptives who use this product may develop discolored skin.
IF YOU DO NOT TAN IN THE SUN, YOU WILL NOT TAN FROM USE OF THIS DEVICE.

§ 63.2-1808. Rights and responsibilities of residents of assisted living facilities; certification of licensure.

A. Any resident of an assisted living facility has the rights and responsibilities enumerated in this section. The operator or administrator of an assisted living facility shall establish written policies and procedures to ensure that, at the minimum, each person who becomes a resident of the assisted living facility:

1. Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgment of having been so informed, which shall be filed in his record;

2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services available in the facility and of any related charges; this shall be reflected by the resident's signature on a current resident's agreement retained in the resident's file;

3. Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the facility for any period of time in conformance with state law;

4. Is afforded confidential treatment of his personal affairs and records and may approve or refuse their release to any individual outside the facility except as otherwise provided in law and except in case of his transfer to another care-giving facility;

5. Is transferred or discharged only when provided with a statement of reasons, or for nonpayment

for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record;

6. In the event a medical condition should arise while he is residing in the facility, is afforded the opportunity to participate in the planning of his program of care and medical treatment at the facility and the right to refuse treatment;

7. Is not required to perform services for the facility except as voluntarily contracted pursuant to a voluntary agreement for services that states the terms of consideration or remuneration and is documented in writing and retained in his record;

8. Is free to select health care services from reasonably available resources;

9. Is free to refuse to participate in human subject experimentation or to be party to research in which his identity may be ascertained;

10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not neglected or ignored by personnel of the facility;

11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;

12. Is encouraged, and informed of appropriate means as necessary, throughout the period of stay to exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and recommend changes in policies and services, free of coercion, discrimination, threats or reprisal;

13. Is permitted to retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents;

14. Is encouraged to function at his highest mental, emotional, physical and social potential;

15. Is free of physical or mechanical restraint except in the following situations and with appropriate safeguards:

a. As necessary for the facility to respond to unmanageable behavior in an emergency situation which threatens the immediate safety of the resident or others;

b. As medically necessary, as authorized in writing by a physician, to provide physical support to a weakened resident;

16. Is free of prescription drugs except where medically necessary, specifically prescribed, and supervised by the attending physician *or nurse practitioner*;

17. Is accorded respect for ordinary privacy in every aspect of daily living, including but not limited to the following:

a. In the care of his personal needs except as assistance may be needed;

b. In any medical examination or health-related consultations the resident may have at the facility;

c. In communications, in writing or by telephone;

d. During visitations with other persons;

e. In the resident's room or portion thereof; residents shall be permitted to have guests or other residents in their rooms unless to do so would infringe upon the rights of other residents; staff may not enter a resident's room without making their presence known except in an emergency or in accordance with safety oversight requirements included in regulations of the Board;

f. In visits with his spouse; if both are residents of the facility they are permitted but not required to share a room unless otherwise provided in the residents' agreements; and

18. Is permitted to meet with and participate in activities of social, religious, and community groups at his discretion unless medically contraindicated as documented by his physician *or nurse practitioner* in his medical record.

B. If the resident is unable to fully understand and exercise the rights and responsibilities contained in this section, the facility shall require that a responsible individual, of the resident's choice when possible, designated in writing in the resident's record, be made aware of each item in this section and the decisions that affect the resident or relate to specific items in this section; a resident shall be assumed capable of understanding and exercising these rights unless a physician determines otherwise and documents the reasons for such determination in the resident's record.

C. The rights and responsibilities of residents shall be printed in at least ~~twelve~~ *12*-point type and posted conspicuously in a public place in all assisted living facilities. The facility shall also post the name and telephone number of the regional licensing supervisor of the Department, the Adult Protective Services' toll-free telephone number, as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program, any sub-state ombudsman program serving the area, and the toll-free number of the Virginia Office for Protection and Advocacy.

D. The facility shall make its policies and procedures for implementing this section available and accessible to residents, relatives, agencies, and the general public.

E. The provisions of this section shall not be construed to restrict or abridge any right ~~which~~ *that* any resident has under law.

F. Each facility shall provide appropriate staff training to implement each resident's rights included in this section.

G. The Board shall adopt regulations as necessary to carry out the full intent of this section.

H. It shall be the responsibility of the Commissioner to ensure that the provisions of this section are observed and implemented by assisted living facilities as a condition to the issuance, renewal, or continuation of the license required by this article.

2. That this act shall take effect 60 days following the effective date of the regulations promulgated by the Board of Medicine and Board of Nursing required by the third enactment clause of this act.

3. That the Board of Medicine and Board of Nursing shall amend regulations governing the licensure of nurse practitioners to be effective within 280 days of enactment of this act. Such amendments shall require inclusion of the nurse practitioner's authority for signatures, certifications, stamps, verifications, affidavits and endorsements in the written protocol between the supervising physician and the nurse practitioner.

4. That the provisions of § 59.1-310.4, as amended by this act, shall only apply to those signs posted or replaced on or after the effective date of this act.