10100492D

HOUSE BILL NO. 87

Offered January 13, 2010

Prefiled January 4, 2010

A BILL to amend and reenact §§ 2.2-3705.5, 2.2-4018, 2.2-4024, 8.01-38, 8.01-38.1, 8.01-52.1, 8.01-195.6, 8.01-195.7, 8.01-243.1, 8.01-385, 8.01-399, 8.01-407, 8.01-581.20:1, 17.1-405, 17.1-407, 17.1-410, 17.1-412, 17.1-900, 32.1-127.1:03, 38.2-117, 38.2-2228.2, 38.2-2800, 38.2-2801, 38.2-2900, 51.1-301, 54.1-2523, 54.1-2900, 54.1-2909, 54.1-2910.1, 54.1-2912.3, 58.1-2501, and 58.1-2502 of the Code of Virginia, to amend the Code of Virginia by adding sections numbered 8.01-273.2 and 38.2-118.1 and by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6467, and to repeal §§ 8.01-20.1 and 8.01-50.1, Article 1 (§§ 8.01-581.1 through 8.01-581.12:2) of Chapter 21.1 of Title 8.01, and §§ 8.01-581.13, 8.01-581.15, 8.01-581.20, 16.1-83.1, and 38.2-5020.1 of the Code of Virginia, relating to the establishment of a system for the compensation of individuals for medical injury caused by an unintended or unexpected adverse consequence or unanticipated outcome of health care rendered or provided to the patient or the failure of a health care provider to render or provide health care to the patient as the exclusive remedy for medical malpractice; establishment of the Medical Injury Compensation Board; requirement that health care providers procure medical incident insurance; taxation of insurers; penalties.

Patron—Marshall, R.G.

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-3705.5, 2.2-4018, 2.2-4024, 8.01-38, 8.01-38.1, 8.01-52.1, 8.01-195.6, 8.01-195.7, 8.01-243.1, 8.01-385, 8.01-399, 8.01-407, 8.01-581.20:1, 17.1-405, 17.1-407, 17.1-410, 17.1-412, 17.1-900, 32.1-127.1:03, 38.2-117, 38.2-2228.2, 38.2-2800, 38.2-2801, 38.2-2900, 51.1-301, 54.1-2523, 54.1-2900, 54.1-2909, 54.1-2910.1, 54.1-2912.3, 58.1-2501, and 58.1-2502 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 8.01-273.2 and 38.2-118.1 and by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6467, as follows:

§ 2.2-3705.5. Exclusions to application of chapter; health and social services records.

The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Health records, except that such records may be personally reviewed by the individual who is the subject of such records, as provided in subsection F of § 32.1-127.1:03.

Where the person who is the subject of health records is confined in a state or local correctional facility, the administrator or chief medical officer of such facility may assert such confined person's right of access to the health records if the administrator or chief medical officer has reasonable cause to believe that such confined person has an infectious disease or other medical condition from which other persons so confined need to be protected. Health records shall only be reviewed and shall not be copied by such administrator or chief medical officer. The information in the health records of a person so confined shall continue to be confidential and shall not be disclosed by the administrator or chief medical officer of the facility to any person except the subject or except as provided by law.

Where the person who is the subject of health records is under the age of 18, his right of access may be asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental rights have been terminated, a court of competent jurisdiction has restricted or denied such access, or a parent has been denied access to the health record in accordance with § 20-124.6. In instances where the person who is the subject thereof is an emancipated minor, a student in a public institution of higher education, or is a minor who has consented to his own treatment as authorized by § 16.1-338 or 54.1-2969, the right of access may be asserted by the subject person.

For the purposes of this chapter, statistical summaries of incidents and statistical data concerning patient abuse as may be compiled by the Commissioner of Behavioral Health and Developmental Services shall be open to inspection and copying as provided in § 2.2-3704. No such summaries or data shall include any patient-identifying information.

2. Applications for admission to examinations or for licensure and scoring records maintained by the Department of Health Professions or any board in that department on individual licensees or applicants. However, such material may be made available during normal working hours for copying, at the requester's expense, by the individual who is the subject thereof, in the offices of the Department of

Health Professions or in the offices of any health regulatory board, whichever may possess the material.

3. Reports, documentary evidence and other information as specified in §§ 2.2-706 and 63.2-104.

4. Investigative notes; proprietary information not published, copyrighted or patented; information obtained from employee personnel records; personally identifiable information regarding residents, clients or other recipients of services; and other correspondence and information furnished in confidence to the Department of Social Services in connection with an active investigation of an applicant or licensee pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2. However, nothing in this section shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information, or other individuals involved in the investigation.

5. Information and records collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Services System and Services pursuant to Article 2.1 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1.

6. Reports and court documents relating to involuntary admission required to be kept confidential pursuant to § 37.2-818.

7. Data formerly required to be submitted to the Commissioner of Health relating to the establishment of new or the expansion of existing clinical health services, acquisition of major medical equipment, or certain projects requiring capital expenditures pursuant to former § 32.1-102.3:4.

8. Information required to be provided to the Department of Health Professions by certain licensees pursuant to § 54.1-2506.1.

9. Information and records acquired (i) during a review of any child death conducted by the State Child Fatality Review team established pursuant to § 32.1-283.1 or by a local or regional child fatality review team to the extent made confidential by § 32.1-283.2; (ii) during a review of any death conducted by a family violence fatality review team to the extent made confidential by § 32.1-283.3; or (iii) during a review of any adult death conducted by the Adult Fatality Review Team to the extent made confidential by § 32.1-283.5.

10. Patient level data collected by the Board of Health and not yet processed, verified, and released, pursuant to § 32.1-276.9, to the Board by the nonprofit organization with which the Commissioner of Health has contracted pursuant to § 32.1-276.4.

11. Records of the Health Practitioners' Monitoring Program Committee within the Department of Health Professions, to the extent such records may identify any practitioner who may be, or who is actually, impaired to the extent disclosure is prohibited by § 54.1-2517.

12. Records submitted as a grant application, or accompanying a grant application, to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Chapter 3.1 (§ 51.5-12.1 et seq.) of Title 51.5, to the extent such records contain (i) medical or mental records, or other data identifying individual patients or (ii) proprietary business or research-related information produced or collected by the applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical or scholarly issues, when such information has not been publicly released, published, copyrighted or patented, if the disclosure of such information would be harmful to the competitive position of the applicant.

13. Any record copied, recorded or received by the Commissioner of Health in the course of an examination, investigation or review of a managed care health insurance plan licensee pursuant to §§ 32.1-137.4 and 32.1-137.5, including books, records, files, accounts, papers, documents, and any or all computer or other recordings.

14. Records, information and statistical registries required to be kept confidential pursuant to §§ 63.2-102 and 63.2-104.

15. All data, records, and reports relating to the prescribing and dispensing of covered substances to recipients and any abstracts from such data, records, and reports that are in the possession of the Prescription Monitoring Program pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 and any material relating to the operation or security of the Program.

16. Records of the Virginia Birth-Related Neurological Injury Compensation Program required to be kept confidential pursuant to § 38.2-5002.2.

17. Records of the State Health Commissioner relating to the health of any person or persons subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1; this provision shall not, however, be construed to prohibit the disclosure of statistical summaries, abstracts or other information in aggregate form.

18. Records containing the names and addresses or other contact information of persons receiving transportation services from a state or local public body or its designee under Title II of the Americans with Disabilities Act, (42 U.S.C. § 12131 et seq.) or funded by Temporary Assistance for Needy Families (TANF) created under § 63.2-600.

19. Records of the Medical Injury Compensation Board required to be confidential pursuant to § 38.2-6459.

§ 2.2-4018. Exemptions from operation of Article 3.

The following agency actions otherwise subject to this chapter shall be exempted from the operation of this article.

1. The assessment of taxes or penalties and other rulings in individual cases in connection with the administration of the tax laws.

2. The award or denial of claims for workers' compensation.

3. The grant or denial of public assistance or social services.

4. Temporary injunctive or summary orders authorized by law.

5. The determination of claims for unemployment compensation or special unemployment.

6. The suspension of any license, certificate, registration or authority granted any person by the Department of Health Professions or the Department of Professional and Occupational Regulation for the dishonor, by a bank or financial institution named, of any check, money draft or similar instrument used in payment of a fee required by statute or regulation.

7. The determination of accreditation or academic review status of a public school or public school division or approval by the Board of Education of a school division corrective action plan required by § 22.1-253.13:3.

8. The award or denial of claims for compensation by the Medical Injury Compensation Board.

§ 2.2-4024. Hearing officers.

A. In all formal hearings conducted in accordance with § 2.2-4020, the hearing shall be presided over by a hearing officer selected from a list prepared by the Executive Secretary of the Supreme Court and maintained in the Office of the Executive Secretary of the Supreme Court. Parties to informal fact-finding proceedings conducted pursuant to § 2.2-4019 may agree at the outset of the proceeding to have a hearing officer preside at the proceeding, such agreement to be revoked only by mutual consent. The Executive Secretary may promulgate rules necessary for the administration of the hearing officer system and shall have the authority to establish the number of hearing officers necessary to preside over administrative hearings in the Commonwealth.

Prior to being included on the list, all hearing officers shall meet the following minimum standards:

1. Active membership in good standing in the Virginia State Bar;

2. Active practice of law for at least five years; and

3. Completion of a course of training approved by the Executive Secretary of the Supreme Court. In order to comply with the demonstrated requirements of the agency requesting a hearing officer, the Executive Secretary may require additional training before a hearing officer shall be assigned to a proceeding before that agency.

B. On request from the head of an agency, the Executive Secretary shall name a hearing officer from the list, selected on a rotation system administered by the Executive Secretary. Lists reflecting geographic preference and specialized training or knowledge shall be maintained by the Executive Secretary if an agency demonstrates the need.

C. A hearing officer shall voluntarily disqualify himself and withdraw from any case in which he cannot accord a fair and impartial hearing or consideration, or when required by the applicable rules governing the practice of law in the Commonwealth. Any party may request the disqualification of a hearing officer by filing an affidavit, prior to the taking of evidence at a hearing, stating with particularity the grounds upon which it is claimed that a fair and impartial hearing cannot be accorded, or the applicable rule of practice requiring disqualification.

The issue shall be determined not less than ten days prior to the hearing by the Executive Secretary of the Supreme Court.

D. Any hearing officer empowered by the agency to provide a recommendation or conclusion in a case decision matter shall render that recommendation or conclusion within ninety days from the date of the case decision proceeding or from a later date agreed to by the named party and the agency. If the hearing officer does not render a decision within ninety days, then the named party to the case decision may provide written notice to the hearing officer and the Executive Secretary of the Supreme Court that a decision is due. If no decision is made within thirty days from receipt by the hearing officer of the notice, then the Executive Secretary of the Supreme Court shall remove the hearing officer from the hearing officer list and report the hearing officer to the Virginia State Bar for possible disciplinary action, unless good cause is shown for the delay.

E. The Executive Secretary shall remove hearing officers from the list, upon a showing of cause after written notice and an opportunity for a hearing. When there is a failure by a hearing officer to render a decision as required by subsection D, the burden shall be on the hearing officer to show good cause for the delay. Decisions to remove a hearing officer may be reviewed by a request to the Executive Secretary for reconsideration, followed by judicial review in accordance with this chapter.

F. This section shall not apply to hearings conducted by (i) any commission or board where all of the members, or a quorum, are present; (ii) the Alcoholic Beverage Control Board, the Virginia Workers'

Compensation Commission, the State Corporation Commission, *the Medical Injury Compensation Board,* the Virginia Employment Commission, the Department of Motor Vehicles under Title 46.2 (§ 46.2-100 et seq.), § 58.1-2409, or Chapter 27 (§ 58.1-2700 et seq.) of Title 58.1, the Motor Vehicle Dealer Board under Chapter 15 (§ 46.2-1500 et seq.) of Title 46.2, or the Board of Towing and Recovery Operators under Chapter 28 (§ 46.2-2800 et seq.) of Title 46.2; or (iii) any panel of a health regulatory board convened pursuant to § 54.1-2400, including any panel having members of a relevant advisory board to the Board of Medicine. All employees hired after July 1, 1986, pursuant to §§ 65.2-201 and 65.2-203 by the Virginia Workers' Compensation Commission to conduct hearings pursuant to its basic laws shall meet the minimum qualifications set forth in subsection A. Agency employees who are not licensed to practice law in the Commonwealth, and are presiding as hearing officers in proceedings pursuant to clause (ii) shall participate in periodic training courses.

G. Notwithstanding the exemptions of subsection A of § 2.2-4002, this article shall apply to hearing officers conducting hearings of the kind described in § 2.2-4020 for the Department of Game and Inland Fisheries, the Virginia Housing Development Authority, the Milk Commission and the Virginia Resources Authority pursuant to their basic laws.

§ 8.01-38. Tort liability of hospitals.

Hospital as referred to in this section shall include any institution within the definition of hospital in § 32.1-123.

No hospital, as defined in this section, shall be immune from liability ~~for negligence or any other tort~~ *in any proceeding pursuant to Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2* on the ground that it is a charitable institution unless (i) such hospital renders exclusively charitable medical services for which service no bill for service is rendered to, nor any charge is ever made to, the patient or (ii) the party ~~alleging such negligence or other tort~~ *seeking recovery for a covered injury in a proceeding pursuant to Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2* was accepted as a patient by such institution under an express written agreement executed by the hospital and delivered at the time of admission to the patient or the person admitting such patient providing that all medical services furnished such patient are to be supplied on a charitable basis without financial liability to the patient. However, ~~notwithstanding the provisions of § 8.01-581.15~~ a hospital ~~which~~ *that* is exempt from taxation pursuant to § 501 (c) (3) of Title 26 of the United States Code (Internal Revenue Code of 1954) and ~~which is insured against liability for negligence or other tort in an amount not less than $500,000 for each occurrence~~ *maintains a policy of medical incident insurance as required by § 38.2-6439* shall not be liable for damage in excess of the limits of such insurance~~, or in actions for medical malpractice pursuant to Chapter 21.1 (§ 8.01-581.1 et seq.) for damages in excess of the amount set forth in § 8.01-581.15~~ *policy*.

§ 8.01-38.1. Limitation on recovery of punitive damages.

In any action accruing on or after July 1, ~~1988~~ *2012*~~,~~ ~~including an action for medical malpractice under Chapter 21.1 (§ 8.01-581.1 et seq.)~~, the total amount awarded for punitive damages against all defendants found to be liable shall be determined by the trier of fact. In no event shall the total amount awarded for punitive damages exceed $350,000. The jury shall not be advised of the limitation prescribed by this section. However, if a jury returns a verdict for punitive damages in excess of the maximum amount specified in this section, the judge shall reduce the award and enter judgment for such damages in the maximum amount provided by this section. *This section shall not be construed as authorizing the Medical Injury Compensation Board from awarding for punitive damages in any amount in any proceeding pursuant to Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2.*

§ 8.01-52.1. Admissibility of expressions of sympathy.

In any wrongful death action brought pursuant to § 8.01-50 *prior to July 1, 2012, or a claim under Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2 brought on or after July 1, 2012,* against a health care provider, ~~or in any arbitration or medical malpractice review panel proceeding related to such wrongful death action,~~ the portion of statements, writings, affirmations, benevolent conduct, or benevolent gestures expressing sympathy, commiseration, condolence, compassion, or a general sense of benevolence, together with apologies that are made by a health care provider or an agent of a health care provider to a relative of the patient, or a representative of the patient about the death of the patient as a result of the unanticipated outcome of health care, shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. A statement of fault that is part of or in addition to any of the above shall not be made inadmissible by this section.

For purposes of this section, unless the context otherwise requires:

"Health care" has the same definition as provided in § ~~8.01-581.1~~ *38.2-6400*.

"Health care provider" has the same definition as provided in § ~~8.01-581.1~~ *38.2-6400*.

"Relative" means a decedent's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half-brother, half-sister, or spouse's parents. In addition, "relative" includes any person who had a family-type relationship with the decedent.

"Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient's

agent.

"Unanticipated outcome" means the outcome of the delivery of health care that differs from an expected result.

§ 8.01-195.6. Notice of claim.

A. Every claim cognizable against the Commonwealth or a transportation district shall be forever barred unless the claimant or his agent, attorney or representative has filed a written statement of the nature of the claim, which includes the time and place at which the injury is alleged to have occurred and the agency or agencies alleged to be liable, within one year after such cause of action accrued. However, if the claimant was under a disability at the time the cause of action accrued, the tolling provisions of § 8.01-229 shall apply.

B. If the claim is against the Commonwealth, the statement shall be filed with the Director of the Division of Risk Management or the Attorney General. If the claim is against a transportation district the statement shall be filed with the chairman of the commission of the transportation district.

C. The notice is deemed filed when it is received in the office of the official to whom the notice is directed. The notice may be delivered by hand, by any form of United States mail service (including regular, certified, registered or overnight mail), or by commercial delivery service.

D. In any action contesting the filing of the notice of claim, the burden of proof shall be on the claimant to establish receipt of the notice in conformity with this section. A signed United States mail return receipt indicating the date of delivery, or any other form of signed and dated acknowledgment of delivery given by authorized personnel in the office of the official with whom the statement is filed, shall be prima facie evidence of filing of the notice under this section.

E. Claims against the Commonwealth involving ~~medical malpractice~~ *injuries resulting from an adverse consequence or unanticipated outcome of health care* shall be subject to the provisions of this article and to the provisions of Chapter ~~21.1~~ *64* (§ ~~8.01-581.1~~ *38.2-6400* et seq.) of ~~this title~~ *Title 38.2*. However, the ~~recovery~~ *amount awarded by the Medical Injury Compensation Board* in such a claim ~~involving medical malpractice~~ shall not exceed the limits imposed by § 8.01-195.3.

§ 8.01-195.7. Statute of limitations.

Every claim cognizable against the Commonwealth or a transportation district under this article shall be forever barred, unless within one year after the cause of action accrues to the claimant the notice of claim required by § 8.01-195.6 is properly filed. An action may be commenced pursuant to § 8.01-195.4 (i) upon denial of the claim by the Attorney General or the Director of the Division of Risk Management or, in the case of a transportation district, by the chairman of the commission of that district or (ii) after the expiration of six months from the date of filing the notice of claim unless, within that period, the claim has been compromised and discharged pursuant to § 8.01-195.5. All claims against the Commonwealth or a transportation district under this article shall be forever barred unless such action is commenced within eighteen months of the filing of the notice of claim.

The limitations periods prescribed by this section and § 8.01-195.6 shall be subject to the tolling provision of § 8.01-229 and the pleading provision of § 8.01-235. ~~Additionally, claims involving medical malpractice in which the notice required by this section and § 8.01-195.6 has been given shall be subject to the provisions of § 8.01-581.9.~~ Notwithstanding the provisions of this section, if notice of claim against the Commonwealth was filed prior to July 1, 1984, any claimant so filing shall have two years from the date such notice was filed within which to commence an action pursuant to § 8.01-195.4.

§ 8.01-243.1. Actions for medical incidents; minors.

Notwithstanding the provisions of § 8.01-229 A and except as provided in subsection C of § 8.01-243, any cause of action accruing on or after July 1, ~~1987~~ *2012*, on behalf of a person who was a minor at the time the cause of action accrued for personal injury or death against a health care provider pursuant to Chapter ~~21.1~~ *64* (§ ~~8.01-581.1~~ *38.2-6400* et seq.) *of Title 38.2* shall be commenced within two years of the date of the last act or omission giving rise to the cause of action except that if the minor was less than eight years of age at the time of the occurrence of the ~~malpractice~~ *covered injury*, he shall have until his tenth birthday to commence an action. Any minor who is ~~ten~~ *10* years of age or older on or before July 1, ~~1987~~ *2012*, shall have no less than two years from that date within which to commence such an action.

§ 8.01-273.2. Motion for judgment; motion to refer to Medical Injury Compensation Board.

A. In any civil action where a party who is a health care provider as defined in § 38.2-6400 moves to refer a cause of action to the Medical Injury Compensation Board for the purposes of determining whether the cause of action involves a covered injury that is compensable only as provided in Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2, the court shall forward the motion to refer together with a copy of the motion for judgment to the Board and stay all proceedings on the cause of action pending an award and notification by the Board of its disposition; provided, however, that the motion to refer the cause of action to the Board shall be filed no later than 120 days after the date of filing a grounds of defense by the party seeking the referral.

B. Upon entry of the order of referral by the court, the clerk of the circuit court shall file with the Board within 30 days a copy of the motion for judgment and the responsive pleadings of all the parties to the action. The clerk shall copy all counsel of record in the civil action on the transmittal letter accompanying the materials being filed with the Board. All parties to the civil action shall be entitled to participate before the Board upon filing a notice of appearance with the Board within 21 days after receipt of the transmittal letter to the clerk of the circuit court. The moving party shall provide the Board with an original and five copies of the following: appropriate assessments, evaluations, and prognoses and such other records obtained during discovery that are reasonably necessary for the determination of whether the injured patient has suffered a covered injury. The medical records and the pleadings referenced in this subsection shall constitute a petition as referenced in § 38.2-6411. The moving party shall be reimbursed for all copying costs upon entry of an award of benefits by the Board.

§ 8.01-385. Definitions.

As used in this chapter:

1. The term "United States" shall be deemed to refer to the United States of America and to include any of its territories, commonwealths, insular possessions, the District of Columbia, and any of its other political subdivisions other than states.

2. The term "court" shall be deemed to include the courts of this Commonwealth, any other person or body appointed by it or acting under its process or authority in a judicial or quasi-judicial capacity, and any other judicial, quasi-judicial, or fact-finding body acting pursuant to the laws of the Commonwealth, including without limitation, the State Corporation Commission, *the Medical Injury Compensation Board,* and the Virginia Workers' Compensation Commission.

3. The term "political subdivision" shall: (i) as applied to the United States, include any other political subdivision other than states and including without limitation the District of Columbia and the Commonwealth of Puerto Rico; (ii) as applied to other countries, include without limitation states, counties, cities, towns, boroughs, and any division thereof recognized and vested with the authority to enact or promulgate ordinances, rules, and regulations having the force or effect of law; (iii) as applied to this Commonwealth and other states of the United States, include without limitation counties, cities, towns, boroughs, and any other division thereof recognized and vested with the authority to enact or promulgate ordinances, rules, and regulations having the force or effect of law.

4. The term "agency" shall be deemed to include without limitation any department, division, commission, association, board, or other administrative body established pursuant to the laws of a jurisdiction.

§ 8.01-399. Communications between physicians and patients.

A. Except at the request or with the consent of the patient, or as provided in this section *or Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2,* no duly licensed practitioner of any branch of the healing arts shall be permitted to testify in any civil action, respecting any information that he may have acquired in attending, examining or treating the patient in a professional capacity.

B. If the physical or mental condition of the patient is at issue in a civil action, the diagnoses, signs and symptoms, observations, evaluations, histories, or treatment plan of the practitioner, obtained or formulated as contemporaneously documented during the course of the practitioner's treatment, together with the facts communicated to, or otherwise learned by, such practitioner in connection with such attendance, examination or treatment shall be disclosed but only in discovery pursuant to the Rules of Court or through testimony at the trial of the action. In addition, disclosure may be ordered when a court, in the exercise of sound discretion, deems it necessary to the proper administration of justice. However, no order shall be entered compelling a party to sign a release for medical records from a health care provider unless the health care provider is not located in the Commonwealth or is a federal facility. If an order is issued pursuant to this section, it shall be restricted to the medical records that relate to the physical or mental conditions at issue in the case. No disclosure of diagnosis or treatment plan facts communicated to, or otherwise learned by, such practitioner shall occur if the court determines, upon the request of the patient, that such facts are not relevant to the subject matter involved in the pending action or do not appear to be reasonably calculated to lead to the discovery of admissible evidence. Only diagnosis offered to a reasonable degree of medical probability shall be admissible at trial.

C. This section shall not (i) be construed to repeal or otherwise affect the provisions of § 65.2-607 relating to privileged communications between physicians and surgeons and employees under the Workers' Compensation Act; (ii) apply to information communicated to any such practitioner in an effort unlawfully to procure a narcotic drug, or unlawfully to procure the administration of any such drug; or (iii) prohibit a duly licensed practitioner of the healing arts, or his agents, from disclosing information as required by state or federal law.

D. Neither a lawyer nor anyone acting on the lawyer's behalf shall obtain, in connection with pending or threatened litigation, information concerning a patient from a practitioner of any branch of the healing arts without the consent of the patient, except through discovery pursuant to the Rules of

Supreme Court as herein provided. However, the prohibition of this subsection shall not apply to:

1. Communication between a lawyer retained to represent a practitioner of the healing arts, or that lawyer's agent, and that practitioner's employers, partners, agents, servants, employees, co-employees or others for whom, at law, the practitioner is or may be liable or who, at law, are or may be liable for the practitioner's acts or omissions;

2. Information about a patient provided to a lawyer or his agent by a practitioner of the healing arts employed by that lawyer to examine or evaluate the patient in accordance with Rule 4:10 of the Rules of Supreme Court; or

3. Contact between a lawyer or his agent and a nonphysician employee or agent of a practitioner of healing arts for any of the following purposes: (i) scheduling appearances, (ii) requesting a written recitation by the practitioner of handwritten records obtained by the lawyer or his agent from the practitioner, provided the request is made in writing and, if litigation is pending, a copy of the request and the practitioner's response is provided simultaneously to the patient or his attorney, (iii) obtaining information necessary to obtain service upon the practitioner in pending litigation, (iv) determining when records summoned will be provided by the practitioner or his agent, (v) determining what patient records the practitioner possesses in order to summons records in pending litigation, (vi) explaining any summons that the lawyer or his agent caused to be issued and served on the practitioner, (vii) verifying dates the practitioner treated the patient, provided that if litigation is pending the information obtained by the lawyer or his agent is promptly given, in writing, to the patient or his attorney, (viii) determining charges by the practitioner for appearance at a deposition or to testify before any tribunal or administrative body, or (ix) providing to or obtaining from the practitioner directions to a place to which he is or will be summoned to give testimony.

E. A clinical psychologist duly licensed under the provisions of Chapter 36 (§ 54.1-3600 et seq.) of Title 54.1 shall be considered a practitioner of a branch of the healing arts within the meaning of this section.

F. Nothing herein shall prevent a duly licensed practitioner of the healing arts, or his agents, from disclosing any information that he may have acquired in attending, examining or treating a patient in a professional capacity where such disclosure is necessary in connection with the care of the patient, the protection or enforcement of a practitioner's legal rights ~~including such rights with respect to medical malpractice actions~~, or the operations of a health care facility or health maintenance organization or in order to comply with state or federal law.

§ 8.01-407. How summons for witness issued, and to whom directed; prior permission of court to summon certain officials and judges; attendance before commissioner of other state; attorney-issued summons.

A. A summons may be issued, directed as prescribed in § 8.01-292, commanding the officer to summon any person to attend on the day and at the place that such attendance is desired, to give evidence before a court, grand jury, arbitrators, magistrate, notary, or any commissioner or other person appointed by a court or acting under its process or authority in a judicial or quasi-judicial capacity. The summons may be issued by the clerk of the court if the attendance is desired at a court or in a proceeding pending in a court. The clerk shall not impose any time restrictions limiting the right to properly request a summons up to and including the date of the proceeding:

If attendance is desired before a commissioner in chancery or other commissioner of a court, the summons may be issued by the clerk of the court in which the matter is pending, or by such commissioner in chancery or other commissioner;

If attendance is desired before a notary or other officer taking a deposition, the summons may be issued by such notary or other officer at the instance of the attorney desiring the attendance of the person sought;

If attendance is sought before a grand jury, the summons may be issued by the attorney for the Commonwealth, or the clerk of the court, at the instance of the attorney for the Commonwealth.

Except as otherwise provided in this subsection, if attendance is desired in a civil proceeding pending in a court or at a deposition in connection with such proceeding, including ~~medical malpractice review panels, and~~ a claim before the Workers' Compensation Commission *or the Medical Injury Compensation Board*, a summons may be issued by an attorney-at-law who is an active member of the Virginia State Bar at the time of issuance, as an officer of the court. An attorney-issued summons shall be on a form approved by the Supreme Court, signed by the attorney and shall include the attorney's address. The summons and any transmittal sheet shall be deemed to be a pleading to which the provisions of § 8.01-271.1 shall apply. A copy of the summons and, if served by a sheriff, all service of process fees, shall be mailed or delivered to the clerk's office of the court in which the case is pending or the Workers' Compensation Commission, as applicable, on the day of issuance by the attorney. The law governing summonses issued by a clerk shall apply mutatis mutandis. When an attorney-at-law transmits one or more attorney-issued subpoenas to a sheriff to be served in his jurisdiction, such subpoenas shall

be accompanied by a transmittal sheet. The transmittal sheet, which may be in the form of a letter, shall contain for each subpoena: (i) the person to be served, (ii) the name of the city or county in which the subpoena is to be served, in parentheses, (iii) the style of the case in which the subpoena was issued, (iv) the court in which the case is pending, and (v) the amount of fees tendered or paid to each clerk in whose court the case is pending together with a photocopy of the payment instrument or clerk's receipt. If copies of the same transmittal sheet are used to send subpoenas to more than one sheriff for service of process, then subpoenas shall be grouped by the jurisdiction in which they are to be served. For each person to be served, an original subpoena and copy thereof shall be included. If the attorney desires a return copy of the transmittal sheet as proof of receipt, he shall also enclose an additional copy of the transmittal sheet together with an envelope addressed to the attorney with sufficient first class postage affixed. Upon receipt of such transmittal, the transmittal sheet shall be date-stamped and, if the extra copy and above-described envelope are provided, the copy shall also be date-stamped and returned to the attorney-at-law in the above-described envelope.

However, when such transmittal does not comply with the provisions of this section, the sheriff may promptly return such transmittal if accompanied by a short description of such noncompliance. An attorney may not issue a summons in any of the following civil proceedings: (i) habeas corpus under Article 3 (§ 8.01-654 et seq.) of Chapter 25 of this title, (ii) delinquency or abuse and neglect proceedings under Article 3 (§ 16.1-241 et seq.) of Chapter 11 of Title 16.1, (iii) issuance of a protective order pursuant to Article 4 (§ 16.1-246 et seq.) or Article 9 (§ 16.1-278 et seq.) of Chapter 11 of Title 16.1, or Chapter 9.1 (§ 19.2-152.8 et seq.) of Title 19.2, (iv) civil forfeiture proceedings, (v) habitual offender proceedings under Article 9 (§ 46.2-351 et seq.) of Chapter 3 of Title 46.2, (vi) administrative license suspension pursuant to § 46.2-391.2 and (vii) petition for writs of mandamus or prohibition in connection with criminal proceedings. A sheriff shall not be required to serve an attorney-issued subpoena that is not issued at least five business days prior to the date that attendance is desired.

In other cases, if attendance is desired, the summons may be issued by the clerk of the circuit court of the county or city in which the attendance is desired.

A summons shall express on whose behalf, and in what case or about what matter, the witness is to attend. Failure to respond to any such summons shall be punishable by the court in which the proceeding is pending as for contempt. When any subpoena is served less than five calendar days before appearance is required, the court may, after considering all of the circumstances, refuse to enforce the subpoena for lack of adequate notice. If any subpoena is served less than five calendar days before appearance is required upon any judicial officer generally incompetent to testify pursuant to § 19.2-271, such subpoena shall be without legal force or effect unless the subpoena has been issued by a judge.

B. No subpoena shall, without permission of the court first obtained, issue for the attendance of the Governor, Lieutenant Governor, or Attorney General of this Commonwealth, a judge of any court thereof; the President or Vice President of the United States; any member of the President's Cabinet; any ambassador or consul; or any military officer on active duty holding the rank of admiral or general.

C. This section shall be deemed to authorize a summons to compel attendance of a citizen of the Commonwealth before commissioners or other persons appointed by authority of another state when the summons requires the attendance of such witness at a place not out of his county or city.

§ 8.01-581.20:1. Admissibility of expressions of sympathy.

In any civil action brought *prior to July 1, 2012, or a claim under Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2 brought on or after July 1, 2012,* by an alleged victim of an unanticipated outcome of health care~~, or in any arbitration or medical malpractice review panel proceeding related to such civil action~~, the portion of statements, writings, affirmations, benevolent conduct, or benevolent gestures expressing sympathy, commiseration, condolence, compassion, or a general sense of benevolence, together with apologies that are made by a health care provider or an agent of a health care provider to the patient, a relative of the patient, or a representative of the patient, shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. A statement of fault that is part of or in addition to any of the above shall not be made inadmissible by this section.

For purposes of this section, unless the context otherwise requires:

"Health care" has the same definition as provided in § ~~8.01-581.1~~ *38.2-6400*.

"Health care provider" has the same definition as provided in § ~~8.01-581.1~~ *38.2-6400*.

"Relative" means a patient's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half-brother, half-sister, or spouse's parents. In addition, "relative" includes any person who has a family-type relationship with the patient.

"Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient's agent.

"Unanticipated outcome" means the outcome of the delivery of health care that differs from an expected result.

§ 17.1-405. Appellate jurisdiction - Administrative agency, Virginia Workers' Compensation Commission, Medical Injury Compensation Board, and domestic relations appeals.

Any aggrieved party may appeal to the Court of Appeals from:

1. Any final decision of a circuit court on appeal from (i) a decision of an administrative agency, or (ii) a grievance hearing decision issued pursuant to § 2.2-3005;

2. Any final decision of the Virginia Workers' Compensation Commission;

3. Any final judgment, order, or decree of a circuit court involving:

a. Affirmance or annulment of a marriage;

b. Divorce;

c. Custody;

d. Spousal or child support;

e. The control or disposition of a child;

f. Any other domestic relations matter arising under Title 16.1 or Title 20;

g. Adoption under Chapter 12 (§ 63.2-1200 et seq.) of Title 63.2; or

h. A final grievance hearing decision issued pursuant to subsection B of § 2.2-3007~~.~~*;*

4. Any interlocutory decree or order entered in any of the cases listed in this section (i) granting, dissolving, or denying an injunction or (ii) adjudicating the principles of a cause~~.~~*; or*

5. Any final decision of the Medical Injury Compensation Board.

§ 17.1-407. Procedures on appeal.

A. The notice of appeal in all cases within the jurisdiction of the court shall be filed with the clerk of the trial court or the clerk of the Virginia Workers' Compensation Commission *or Medical Injury Compensation Board*, as appropriate, and a copy of such notice shall be mailed or delivered to all opposing counsel and parties not represented by counsel, and to the clerk of the Court of Appeals. The clerk shall endorse thereon the day and year he received it.

B. Appeals pursuant to § 17.1-405 are appeals of right. The clerk of the Court of Appeals shall refer each case for which a notice of appeal has been filed, other than appeals in criminal cases, to a panel of the court as the court may direct.

C. Each petition for appeal in a criminal case shall be referred to one or more judges of the Court of Appeals as the court shall direct. A judge to whom the petition is referred may grant the petition on the basis of the record without the necessity of oral argument. The clerk shall refer each appeal for which a petition has been granted to a panel of the court as the court shall direct.

D. If the judge to whom a petition is initially referred does not grant the appeal, counsel for the petitioner shall be entitled to state orally before a panel of the court the reasons why his appeal should be granted. If all of the judges of the panel to whom the petition is referred are of the opinion that the petition ought not be granted, the order denying the appeal shall state the reasons for the denial. Thereafter, no other petition in the matter shall be entertained in the Court of Appeals.

§ 17.1-410. Disposition of appeals; finality of decisions.

A. Each appeal of right taken to the Court of Appeals and each appeal for which a petition for appeal has been granted shall be considered by a panel of the court.

When the Court of Appeals has (i) rejected a petition for appeal, (ii) dismissed an appeal in any case in accordance with the Rules of Court, or (iii) decided an appeal, its decision shall be final, without appeal to the Supreme Court, in:

1. Traffic infraction and misdemeanor cases where no incarceration is imposed;

2. Cases originating before any administrative agency or the Virginia Workers' Compensation Commission *or Medical Injury Compensation Board*;

3. Cases involving the affirmance or annulment of a marriage, divorce, custody, spousal or child support or the control or disposition of a juvenile and other domestic relations cases arising under Title 16.1 or Title 20, or involving adoption under Chapter 12 (§ 63.2-1200 et seq.) of Title 63.2;

4. Appeals in criminal cases pursuant to §§ 19.2-398 and 19.2-401. Such finality of the Court of Appeals' decision shall not preclude a defendant, if he is convicted, from requesting the Court of Appeals or Supreme Court on direct appeal to reconsider an issue which was the subject of the pretrial appeal; and

5. Appeals involving involuntary treatment of prisoners pursuant to § 53.1-40.1.

B. Notwithstanding the provisions of subsection A, in any case other than an appeal pursuant to § 19.2-398, in which the Supreme Court determines on a petition for review that the decision of the Court of Appeals involves a substantial constitutional question as a determinative issue or matters of significant precedential value, review may be had in the Supreme Court in accordance with the provisions of § 17.1-411.

§ 17.1-412. Affirmance, reversal, or modification of judgment; petition for appeal to Supreme Court upon award of new trial.

A judgment, order, conviction, or decree of a circuit court or award of the Virginia Workers'

Compensation Commission *or Medical Injury Compensation Board* may be affirmed, or it may be reversed, modified, or set aside by the Court of Appeals for errors appearing in the record. If the decision of the Court of Appeals is to reverse and remand the case for a new trial, any party aggrieved by the granting of the new trial may accept the remand or proceed to petition for appeal in the Supreme Court pursuant to § 17.1-411.

§ 17.1-900. Definitions and application of chapter.

As used in this chapter, unless the context requires a different meaning:

"Commission" means the Judicial Inquiry and Review Commission provided for in Article VI, Section 10 of the Constitution of Virginia.

"Judge" means a justice of the Supreme Court, judge of the Court of Appeals, judge of a circuit or district court, member of the State Corporation Commission, ~~or~~ ~~a~~ member of the Virginia Workers' Compensation Commission, *or member of the Medical Injury Compensation Board* and includes (i) persons who have been elected or appointed to be judges but have not taken the oath of office as judge as well as persons who have taken such oath, (ii) judges designated under § 17.1-105, (iii) judges under temporary recall under § 17.1-106, (iv) judges pro tempore under § 17.1-109 and (v) special justices appointed pursuant to § 37.2-803, all of whom shall be subject to investigations and proceedings under the provisions of this chapter.

"Term" means (i) the period of time between either election or appointment of service as a judge and the first taking of the oath of office, (ii) each period of time for which the person was either elected or appointed as a judge, and (iii) any period of time after retirement during which the person hears cases as a retired judge.

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by other provisions of state law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, except as provided in subsections E and F of this section and subsection B of § 8.01-413.

2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § ~~8.01-581.1~~ *38.2-6400*, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" shall include any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

"Psychotherapy notes" means comments, recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session with an individual or a group, joint, or family counseling session that are separated from the rest of the individual's health record. "Psychotherapy notes" shall not include annotations relating to medication and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual's progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;

2. Except where specifically provided herein, the health records of minors; or

3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3.

D. Health care entities may, and, when required by other provisions of state law, shall, disclose health records:

1. As set forth in subsection E, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969 or (b) the minor himself, if he has consented to his own treatment pursuant to § 54.1-2969, or (iii) in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H, pursuant to a search warrant or a grand jury subpoena, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413. Regardless of the manner by which health records relating to an individual are compelled to be disclosed pursuant to this subdivision, nothing in this subdivision shall be construed to prohibit any staff or employee of a health care entity from providing information about such individual to a law-enforcement officer in connection with such subpoena, search warrant, or court order;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease,

public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 37.2-710, 37.2-839, 53.1-40.10, 54.1-2400.6, 54.1-2400.7, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.2-1509, and 63.2-1606;

7. Where necessary in connection with the care of the individual;

8. In connection with the health care entity's own health care operations or the health care operations of another health care entity, as specified in 45 C.F.R. § 164.501, or in the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Chapter 10 (§ 37.2-1000 et seq.) of Title 37.2;

12. To the guardian ad litem and any attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a commitment proceeding under § 19.2-169.6, 19.2-176, or 19.2-177.1, Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2, Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, or a judicial authorization for treatment proceeding pursuant to Chapter 11 (§ 37.2-1100 et seq.) of Title 37.2;

13. To a magistrate, the court, the evaluator or examiner required under § 16.1-338, 16.1-339, 16.1-342, or 37.2-815, a community services board or behavioral health authority or a designee of a community services board or behavioral health authority, or a law-enforcement officer participating in any proceeding under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, § 19.2-169.6, 19.2-176, or 19.2-177.1, or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 regarding the subject of the proceeding, and to any health care provider evaluating or providing services to the person who is the subject of the proceeding or monitoring the person's adherence to a treatment plan ordered under those provisions. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained;

14. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

15. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

16. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

17. To third-party payors and their agents for purposes of reimbursement;

18. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

19. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

20. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

21. Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § 32.1-127;

22. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

23. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

24. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian

or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

25. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

26. To the Office of the Inspector General for Behavioral Health and Developmental Services pursuant to Article 3 (§ 37.2-423 et seq.) of Chapter 4 of Title 37.2;

27. To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4 of this title, pursuant to subdivision 1 of this subsection;

28. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

29. To law-enforcement officials, in response to their request, for the purpose of identifying or locating a suspect, fugitive, person required to register pursuant to § 9.1-901 of the Sex Offender and Crimes Against Minors Registry Act, material witness, or missing person, provided that only the following information may be disclosed: (i) name and address of the person, (ii) date and place of birth of the person, (iii) social security number of the person, (iv) blood type of the person, (v) date and time of treatment received by the person, (vi) date and time of death of the person, where applicable, (vii) description of distinguishing physical characteristics of the person, and (viii) type of injury sustained by the person;

30. To law-enforcement officials regarding the death of an individual for the purpose of alerting law enforcement of the death if the health care entity has a suspicion that such death may have resulted from criminal conduct;

31. To law-enforcement officials if the health care entity believes in good faith that the information disclosed constitutes evidence of a crime that occurred on its premises;

32. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of this title;

33. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment; ~~and~~

34. To notify a family member or personal representative of an individual who is the subject of a proceeding pursuant to Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition, when the individual has the capacity to make health care decisions and (i) the individual has agreed to the notification, (ii) the individual has been provided an opportunity to object to the notification and does not express an objection, or (iii) the health care provider can, on the basis of his professional judgment, reasonably infer from the circumstances that the individual does not object to the notification. If the opportunity to agree or object to the notification cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the health care provider may notify a family member or personal representative of the individual of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition if the health care provider, in the exercise of his professional judgment, determines that the notification is in the best interests of the individual. Such notification shall not be made if the provider has actual knowledge the family member or personal representative is currently prohibited by court order from contacting the individual*;*

35. In connection with the work of any panel created pursuant to subsection D of § 38.2-6411; and

36. To the Medical Injury Compensation Board if authorized or required pursuant to any provision of Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2.

Notwithstanding the provisions of subdivisions 1 through ~~34~~ *36* of this subsection, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any

accusation of wrongful conduct; (iii) in the discharge of the duty, in accordance with subsection B of § 54.1-2400.1, to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Requests for copies of health records shall (i) be in writing, dated and signed by the requester; (ii) identify the nature of the information requested; and (iii) include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within 15 days of receipt of a request for copies of health records, the health care entity shall do one of the following: (i) furnish such copies to any requester authorized to receive them; (ii) inform the requester if the information does not exist or cannot be found; (iii) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (iv) deny the request (a) under subsection F, (b) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (c) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of state law.

F. Except as provided in subsection B of § 8.01-413, copies of an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical psychologist determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name .....

Health Care Entity's Name .....

Person, Agency, or Health Care Entity to whom disclosure is to be made .....

Information or Health Records to be disclosed .....

Purpose of Disclosure or at the Request of the Individual .....

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of

confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event) .....

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign .....

Relationship or Authority of Legal Representative .....

Date of Signature .....

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9 of this subsection, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the

recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8 of this subsection.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivision 5 or 8 of this subsection from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if

subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, "individual" shall subsume a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.

§ 38.2-117. Personal injury liability.

"Personal injury liability insurance" means insurance against legal liability of the insured, and against loss, damage or expense incident to a claim of such liability, arising out of the death or injury of any person, or arising out of injury to the economic interests of any person as the result of *(i)* negligence in rendering expert, fiduciary, or professional service *or (ii) an unintended or unexpected adverse consequence or unanticipated outcome of health care delivered by any provider of health care*, but not including any class of insurance specified in § 38.2-119.

Any policy of personal injury liability insurance may include appropriate provisions obligating the insurer to pay medical, hospital, surgical, and funeral expenses arising out of the death or injury of any person, regardless of any legal liability of the insured.

§ 38.2-118.1. Medical incident insurance.

"Medical incident insurance" means insurance coverage against the legal liability of a health care provider, as defined in § 38.2-6400, against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of an unintended or unexpected adverse consequence or unanticipated outcome of health care delivered by any provider of health care. Medical incident insurance may include appropriate provisions obligating the insurer to pay medical, chiropractic, hospital, surgical, and other sums compensable under Chapter 64 (§ 38.2-6400 et seq.) arising out of the death or injury of an injured patient, regardless of any legal liability of the health care provider.

§ 38.2-2228.2. Certain claims to be reported to the Commission.

All ~~medical malpractice~~ claims *filed pursuant to Chapter 64 (§ 38.2-6400 et seq.),* settled, or adjudicated to final judgment against a person, corporation, firm, or entity providing health care, and any such claim closed without payment during each calendar year shall be reported annually to the Commission by the insurer of the health care provider. The reports shall not identify the parties. The report shall state the following data, to the extent applicable, in a format prescribed by the Commission:

1. The nature of the claim and damages asserted;
2. The principal medical and legal issues;
3. Attorneys' fees and expenses paid in connection with the claim or defense, to the extent these amounts are known;
4. Attorneys' fees and expenses reserved in connection with the claim or defense;
5. The amount of the settlement or judgment awarded to the claimant to the extent this amount is known;
6. The specialty of each health care provider;
7. The date the claim was reported to the company;
8. The date the loss occurred;
9. The date the claim was closed;
10. The date and amount of the initial reserve;
11. The amount of loss paid by the insurer if different from the amount of settlement or judgment awarded to the claimant; and
12. Any other pertinent information the Commission may require as is consistent with the provisions of this section.

The report shall include a statistical summary of the information collected in addition to an individual report on each claim. The report shall be submitted in an electronic format. Statistical summaries and individual closed claim reports shall be a matter of public record, except that data reported under item 10 shall, at the request of the reporting insurer, not be disclosed in the public record.

The report shall be filed electronically by July 1 of the year following the applicable calendar year; however, a report with data for calendar years 2002, 2003, and 2004 shall be filed by September 1, 2005.

§ 38.2-2800. Definitions.

As used in this chapter:

"Association" means the joint underwriting association established pursuant to the provisions of this chapter.

"Incidental coverage" means any other type of liability insurance covering activities directly related to the continued and efficient delivery of health care that~~:~~ (i) cannot be obtained in the voluntary market because medical ~~malpractice~~ *incident* insurance is being provided pursuant to this chapter~~;~~ and (ii) cannot be obtained through other involuntary market mechanisms.

"Liability insurance" includes the classes of insurance defined in §§ 38.2-117 through 38.2-119 and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125, and 38.2-130 through 38.2-132.

~~"Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence in rendering or failing to render professional service by any provider of health care.~~

"Net direct premiums written" means gross direct premiums written in this Commonwealth on all

policies of liability insurance less, (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

"Provider of health care" means any of the following deemed by the Commission to be necessary for the delivery of health care: (i) a physician and any other individual licensed or certified pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; (ii) a nurse, dentist, or pharmacist licensed pursuant to Title 54.1; (iii) any health facility licensed or eligible for licensure pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2; and (iv) any other group, type, or category of individual or health-related facility that the Commission finds to be necessary for the continued delivery of health care after providing notice and opportunity to be heard.

§ 38.2-2801. Association activation; members; purpose; determinations by Commission; powers of association.

A. The Commission shall activate a joint underwriting association if, after investigation, notice, and hearing, it finds that medical ~~malpractice~~ *incident* insurance cannot be made reasonably available in the voluntary market for a significant number of any class, type, or group of providers of health care. The association shall consist of all insurers licensed to write and engaged in writing ~~liability~~ *medical incident* insurance within ~~this~~ *the* Commonwealth on a direct basis except those exempted from rate regulation by subsection C of § 38.2-1902. Each such insurer shall be a member of the association as a condition of its license to write liability insurance in ~~this~~ *the* Commonwealth.

B. The purpose of the association shall be to provide a market for medical ~~malpractice~~ *incident* insurance on a self-supporting basis without subsidy from its members.

C. 1. The association shall not commence underwriting operations for any class, type or group of providers of health care until it is activated by the Commission. At the direction of the Commission, the association shall commence operations in accordance with the provisions of this chapter.

2. If the Commission determines at any time that medical ~~malpractice~~ *incident* insurance can be made reasonably available in the voluntary market for any class, type or group of providers of health care, the association shall, at the direction of the Commission, cease its underwriting operations for that class, type or group of providers of health care.

D. The Commission shall also determine after investigation and a hearing whether the association shall be the exclusive source of medical ~~malpractice~~ *incident* insurance for any class, type or group of providers of health care and the type of policy or policies that shall be issued to any class, type or group of providers of health care. If the Commission determines that a claims-made policy will be issued to any class, type or group of providers of health care, the Commission shall also provide for the guaranteed availability of insurance that covers claims that (i) result from incidents occurring during periods when the basic claims-made policies are in force, and (ii) are reported after the expiration of the basic claims-made policies. The Commission may from time to time after an investigation and hearing reexamine and reconsider any determination made pursuant to this subsection.

E. Pursuant to this chapter and the plan of operation required by § 38.2-2804, the association shall have the power on behalf of its members to: (i) issue, or cause to be issued, policies of medical ~~malpractice~~ *incident* insurance to applicants, including incidental coverages, subject to limits as specified in the plan of operation but not to exceed $2 million for each claimant under any one policy and $6 million for all claimants under one policy in any one year; (ii) underwrite the insurance and adjust and pay losses on the insurance; (iii) appoint a service company or companies to perform the functions enumerated in this subsection; (iv) assume reinsurance from its members; and (v) reinsure its risks in whole or in part.

§ 38.2-2900. Definitions.

As used in this chapter:

"Association" means the joint underwriting association established pursuant to the provisions of this chapter.

"Commercial liability insurance" means the commercial classes of insurance defined in §§ 38.2-117 and 38.2-118, but for the purposes of this chapter, does not include medical ~~malpractice~~ *incident* insurance as defined in § ~~38.2-2800~~ *38.2-118.1*, nuclear liability or any risks, lines, or subclassifications that are determined by the Commission to be uninsurable; provided, no such determination shall be based solely upon evidence that no insurers are then insuring such risk, line, or subclassification. The Commission may exclude from this definition any other line, subclassification or type of commercial liability insurance as it deems appropriate.

"Incidental coverage" means any other type of liability insurance covering activities directly related to the continued and efficient delivery of business and professional services that: (i) cannot be separately obtained in the voluntary market because commercial liability insurance is being provided pursuant this chapter; and (ii) cannot be separately obtained through other involuntary market mechanisms.

"Market assistance plan" means a voluntary association of insurers and insurance agents licensed to do business in the Commonwealth that is formed, pursuant to a plan of operation filed with and

approved by the Commission, to assist with the individual placement of commercial liability insurance coverage that is not reasonably available on the voluntary market.

"Net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance. For the purposes of this chapter, "liability insurance" means the classes of insurance defined in §§ 38.2-117 through 38.2-119, and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125 and 38.2-130 through 38.2-132.

CHAPTER 64.

COMPENSATION FOR INJURIES RESULTING FROM MEDICAL INCIDENTS.

§ 38.2-6400. Definitions.

As used in this chapter:

"Award" means the grant or denial of benefits or other relief under this chapter or any regulation adopted pursuant thereto.

"Board" means the Medical Injury Compensation Board established pursuant to this chapter.

"Claimant" means an injured patient who files a claim pursuant to this chapter for compensation for a covered injury incurred by him.

"Covered injury" means a medical injury caused by an unintended or unexpected adverse consequence or unanticipated outcome of (i) health care rendered or provided to the patient or (ii) the failure of a health care provider to render or provide health care to the patient.

"Filed" means hand delivered to the Board's office in Richmond; sent by telegraph, electronic mail, or facsimile transmission; or posted at any post office of the United States Postal Service by certified or registered mail. Filing by first-class mail, telegraph, electronic mail, or facsimile transmission shall be deemed completed only when the application actually reaches the Board.

"Health care" means any act, professional services in nursing homes, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical diagnosis, care, treatment, or confinement.

"Health care provider" means (i) a physician; (ii) a hospital; (iii) a professional limited liability company, corporation, partnership, limited liability company, or any other entity, except a state-operated facility, that employs or engages a physician and that primarily renders health care services; or (iv) a director, officer, employee, independent contractor, or agent of any individual or entity described in clause (i), (ii), or (iii), acting within the course and scope of his employment or engagement as related to health care services.

"Hospital" means a public or private institution licensed pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2.

"Impartial physician" means a physician who (i) has not examined, treated, or been consulted regarding the claimant or his family; (ii) does not anticipate examining, treating, or being consulted regarding the claimant or his family; or (iii) has not been an employee, partner, or co-proprietor of the health care provider against whom the claim is asserted.

"Injured patient" means a patient incurring a medical injury.

"Medical incident" means a rendering or provision of health care, or a failure of a health care provider to render or provide health care to a patient, that causes a medical injury.

"Medical injury" means an impairment of the physical condition, or the death, of a patient.

"Medical malpractice action" means any tort action or breach of contract action for personal injuries or wrongful death, based on health care services rendered, or which should have been rendered, by a health care provider to a patient.

"Patient" means an individual who receives or should have received health care from a health care provider. Patient does not include any individual who is given health care in an emergency situation that exempts the health care provider from liability for his emergency services in accordance with § 8.01-225 or 44-146.23.

"Physician" means a person licensed to practice medicine or osteopathy in this Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Professional services in nursing homes" means services provided in a nursing home, as that term is defined in clause (iv) of the definition of health care provider in this section, by a health care provider related to health care, staffing to provide patient care, psycho-social services, personal hygiene, hydration, nutrition, fall assessments or interventions, patient monitoring, prevention and treatment of medical conditions, diagnosis, or therapy.

"Unanticipated outcome" means the outcome of the delivery of health care that differs from an expected result.

§ 38.2-6401. Scope.

This chapter applies to all claims for covered injuries occurring in this Commonwealth on and after July 1, 2012.

§ 38.2-6402. When compensation not allowed under this chapter; burden of proof.

A. No compensation shall be awarded to an individual for a birth-related neurological injury as defined in § 38.2-5001.

B. The person or entity asserting any defense established in subsection A shall have the burden of proof with respect thereto.

§ 38.2-6403. Medical Injury Compensation Board; number, election and terms of members; vacancies; chairman; members to devote entire time to office.

A. The Board shall consist of three members. Members of the Board shall be elected by the joint vote of the two houses of the General Assembly for regular staggered terms of six years. At the regular session of the General Assembly convened in each even-numbered year, one member shall be elected for a regular six-year term. No person shall be eligible to serve as a member of the Board unless at the time of his election or appointment he is a qualified voter under the Constitution and laws of this Commonwealth. Each member of the Board shall have the qualifications prescribed for judges of courts of record.

B. A majority of the members shall constitute a quorum for the exercise of the Board's functions, whether there be a vacancy in the Board or not, but a quorum shall not be necessary for the exercise of its administrative functions.

C. Whenever a vacancy in the Board occurs or exists when the General Assembly is in session, the General Assembly shall elect a successor for the unexpired term. If the General Assembly is not in session, the Governor shall forthwith appoint pro tempore a qualified person to fill the vacancy for a term ending 30 days after the commencement of the next session of the General Assembly, and the General Assembly shall elect a successor for the unexpired term.

D. The Board shall elect one of its number chairman for a one-year term commencing on February 1 of each year. Each member of the Board shall devote his entire time to the duties of his office and shall not hold any position of trust or profit or engage in any occupation or business interfering or inconsistent with his duties as such member.

E. The Board shall be provided with adequate offices in some suitable building in the City of Richmond, in which the records shall be kept and its official business transacted during regular business hours. The Board shall also be provided with necessary office furniture, stationery, and other supplies.

F. The Board or any member thereof may hold sessions at any place within the Commonwealth as may be deemed necessary by the Board.

G. The members of the Board and its subordinates and employees shall not, directly or indirectly, own any securities of, have any pecuniary interest in, or hold any position with any medical incident insurance company or any health care provider; nor shall any such person engage in the private practice of law.– This subsection shall not prevent any such person from being a policyholder in any insurance company in accordance with such rules as the Board may adopt. Any member of the Board who violates this subsection may be censured or removed from office in the manner provided by Article VI, Section 10 of the Constitution of Virginia. Any subordinate or employee of the Board who violates this section may be removed from office by the Board.

H. Any person elected or appointed to be a member of the Board shall qualify by taking and subscribing the oath required by Article II, Section 7 of the Constitution of Virginia. If any member shall fail to so qualify within 30 days after the commencement of his term of office, such office shall become vacant.

I. All salaries and expenses of the Board shall be audited and paid out of the state treasury in the manner prescribed for similar expenses in other departments or branches of state government.

§ 38.2-6404. Powers and duties of the Board.

A. It shall be the duty of the Board to administer this chapter and adjudicate issues and controversies relating thereto. The Board is authorized to hear and pass upon all claims filed pursuant to this chapter.

B. In all matters within the jurisdiction of the Board, it shall have the powers of a court of record to administer oaths, to compel the attendance of witnesses and the production of documents, to punish for contempt or disobedience of its orders as is vested in courts and judges by § 18.2-456, or Chapter 21 (§ 19.2-339 et seq.) of Title 19.2., to examine or cause to be examined such parts of the books and records of the parties to a proceeding as relate to questions in dispute arising in instances in which the Board has power to award compensation, and to enforce compliance with its lawful orders or requirements by adjudging and enforcing by its own appropriate process such fines or other penalties as may be prescribed or authorized by law. Such attendance, production, and examination shall be required by subpoena of the Board upon timely request therefor by any party to a proceeding before it, unless the Board finds that the issuance of such subpoena is for dilatory purposes, would cause substantial inconvenience to such witnesses, or is not likely to produce significant relevant evidence.

C. The county or city sheriff or town sergeant, and their respective deputies, shall serve subpoenas

of the Board and shall receive the same fees as are now provided by law for like civil actions. Each witness who appears in obedience to such subpoena of the Board shall receive for attendance the fees and mileage for witnesses in civil cases in courts. In the administration and enforcement of all laws within its jurisdiction, the Board shall have the power to adopt regulations, to impose and collect such fines or other penalties as are provided by law, to enter appropriate orders, and to issue temporary and permanent injunctions.

D. The Board shall have the power to retain counsel for and to indemnify its employees and agents who were or are parties or are threatened to be made parties to any threatened, pending, or completed action, suit, or proceeding whether civil, criminal, administrative, arbitrative, or investigative, by reason of the fact that they are or were employees or agents of the Board, including attorney fees reasonably incurred by them in connection with such action, suit, or proceeding if the Board or any court of record to whom the matter shall be submitted shall find the employees or agents acting in good faith and in a manner they reasonably believe to be in the best interest of the duties assigned to them by law or the Board.

E. The Board shall appoint a clerk, bailiffs, all necessary regular and special counsel notwithstanding the provisions of Chapter 5 (§ 2.2-500 et seq.) of Title 2.2, and such other subordinates and employees as may be necessary to the proper discharge of its duties, all of whom shall serve at the pleasure of the Board. The bailiffs of the Board shall, in all matters within the jurisdiction of the Board, have the powers, discharge the functions, and perform the duties of a sheriff under the law. They shall preserve order during the public sessions of the Board; may make arrests and serve and make return on any writ or process awarded by the Board; and shall execute any writ, order, or process of execution awarded upon the findings or judgments of the Board in any matter within its jurisdiction. They shall exercise other powers and perform any duties as may be delegated to them.

F. The Board shall publish and, upon request, furnish free of charge, such blank forms and literature as it shall deem requisite to facilitate or promote the efficient administration of this chapter.

G. The Commission shall prescribe its own rules of practice and procedure not inconsistent with those made by the General Assembly. Such rules shall be printed and entered upon the records of the Board. Copies of such rules shall be furnished to county and city clerks and to any citizen of this Board who makes application therefor.

H. Before adopting any regulation, the Board shall give reasonable notice of its contents and shall afford interested persons having objections thereto an opportunity to present evidence and be heard. Every such order and notice of every such rule or regulation finally adopted by the Board shall be published in the next annual report of the Board, and a copy of the order, rule, or regulation shall be delivered by the Board to every person affected by it who requests a copy, and copies shall be available to the public by application therefor to the Board. The procedure for adoption of rules and regulations by Board shall be consistent with the provisions of Article 2 (§ 2.2-4006 et seq.) of the Administrative Process Act.

I. The Board, on hearing of all complaints, proceedings, contests, or controversies in which it shall be called upon to decide or render judgment, shall observe and administer the common and statute law rules of evidence as observed and administered by the courts of the Commonwealth.

§ 38.2-6405. Presumption of acceptance of provisions of chapter.

Every health care provider and injured patient, except as otherwise expressly provided in this chapter, shall be conclusively presumed to have accepted the provisions of this chapter respectively to pay and accept compensation for any covered injury and shall be bound thereby.

§ 38.2-6406. Injured patient's rights under chapter exclude all others.

A. The rights and remedies granted in this chapter to an injured patient, when his health care provider and he have accepted the provisions of this chapter respectively to pay and accept compensation on account of a covered injury, shall exclude all other rights and remedies of the injured patient, his personal representative, parents, dependents, or next of kin, at common law or otherwise, arising out of or related to the covered injury, including any claims by injured patient, his personal representative, parents, dependents, or next of kin for medical malpractice or that, by substantive law, are derivative of the claim with respect to the injured patient's medical injury, including but not limited to claims of emotional distress proximately related to the injury.

B. Nothing in this chapter shall bar a health care provider from voluntarily agreeing to pay an injured patient compensation above and beyond those benefits provided for in this chapter.

C. Notwithstanding anything to the contrary in this section, a civil action shall not be foreclosed against a health care provider where there is clear and convincing evidence that the health care provider intentionally or willfully caused or intended to cause an injury, provided that such suit is filed prior to and in lieu of payment of an award under this chapter. Such suit shall be filed before the award of the Board becomes conclusive and binding.

D. The limit of liability of a hospital as provided in § 8.01-38 is not affected by this chapter.

E. This chapter provides the exclusive procedure for asserting any medical malpractice action

occurring on or after July 1, 2012.

§ 38.2-6407. Notice of medical incident.

A. Every injured patient or his representative shall immediately on the occurrence of a medical incident or as soon thereafter as practicable, give or cause to be given to the health care provider a written notice of the medical incident.

B. The notice shall state the name and address of the injured patient, the time and place of the medical incident, and the nature and cause of the medical incident and the injury.

C. No defect or inaccuracy in the notice shall be a bar to compensation unless the health care provider shall prove that his interest was prejudiced thereby and then only to such extent as the prejudice.

§ 38.2-6408. Jurisdiction of Board.

All questions arising under this chapter, if not settled by agreements of the parties interested therein with the approval of the Board, shall be determined by the Board, except as otherwise herein provided.

§ 38.2-6409. Agreement as to compensation; penalty.

A. If after injury or death the health care provider and the injured patient or his dependents reach an agreement in regard to compensation or in compromise of a claim for compensation under this chapter, a memorandum of the agreement in the form prescribed by the Board shall be filed with the Board for approval. The agreement may be prepared by the injured patient, the health care provider, or the provider's medical incident insurance carrier. If approved, the agreement shall be binding, and an award of compensation entered upon such agreement shall be for all purposes enforceable as provided by § 38.2-6419. If not approved, the same agreement shall be void. Such agreement may be approved only when the Board is clearly of the opinion that the best interests of the injured patient or his dependents will be served thereby. The approval of such agreement shall bind an infant or incapacitated dependents affected thereby. Any agreement entered into during the pendency of an appeal to the Court of Appeals shall be effective only with the approval of the Board as herein provided.

B. A health care provider or insurance carrier that fails to file a memorandum of such agreement with the Board within 14 calendar days of the date of its complete written execution as indicated thereon may be subject to a fine not to exceed $1,000 and to any other appropriate sanctions of the Board.

C. Nothing herein contained shall be construed so as to prevent settlements made by and between the injured patient and health care provider, but rather to encourage them, so long as the amount of compensation and the time and manner of payment are approved by the Board. A copy of such settlement agreement shall be filed with the Board by the health care provider.

§ 38.2-6410. Board authorized to hear and determine claims; venue; time for filing claims; limitations.

A. If the health care provider and the injured patient or his dependents fail to reach an agreement in regard to compensation under this chapter, either party may make application to the Board for a hearing in regard to the matters at issue and for a ruling thereon.

B. Immediately after such application has been received, the Board shall set the date for a hearing, which shall be held as soon as practicable, and shall notify the parties at issue of the time and place of such hearing. The hearing shall be held at the offices of the Board in Richmond or, if the Board in its discretion finds it appropriate, in the city or county where the injury occurred.

C. When a circuit court refers a civil action to the Board pursuant to § 8.01-273.2 for the purposes of determining whether the cause of action satisfies the requirements of this chapter, the Board shall set the matter for hearing pursuant to § 38.2-6415. The Board shall communicate its decision to the referring circuit court in due course.

D. The right to compensation under this chapter shall be forever barred unless a claim is filed with the Board within two years after the medical incident. Death benefits payable under this chapter shall be payable only if (i) death results from the medical incident, (ii) a claim for benefits under this chapter has been filed within two years after the medical incident, and (iii) the claim for such death benefits is filed within two years from the date of death. No limitation of time provided in this chapter for the giving of notice or making claim under this chapter shall run against any person who is incapacitated or under 18 years of age, so long as he has no guardian, trustee, or conservator.

§ 38.2-6411. Filing of claims; review by Board of Medicine; review by Department of Health; report by panel of physicians; filing of responses; medical records.

A. 1. In all claims filed under this chapter, the claimant shall file with the Board a petition, setting forth the following information:

a. The name of the claimant;

b. The address of the injured claimant;

c. The name and address of any health care provider providing health care to the claimant;

d. A description of the medical injury for which claim is made;

e. The time and place where the medical injury occurred;

f. A brief statement of the facts and circumstances surrounding the medical incident giving rise to the claim;

g. All available relevant medical records relating to the medical injury and an identification of any unavailable records known to the claimant and the reasons for their unavailability;

h. Appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the claimant on account of a covered injury;

i. Documentation of expenses and services incurred to date as a result of the medical injury, which indicates whether such expenses and services have been paid for, and if so, by whom; and

j. Documentation of any applicable private or governmental source of services or reimbursement relative to the medical injury.

2. The claimant shall furnish the Board with as many copies of the petition as required for service upon the Program, any health care provider named in the petition, the Board of Medicine, and the Department of Health, along with a $15 filing fee. Upon receipt of the petition the Board shall mail copies of the petition to any health care provider named in the petition, the Board of Medicine, and the Department of Health.

B. Upon receipt of the petition or the filing of a claim relating to the conduct of a physician, the Department of Health Professions shall investigate the petition or claim, utilizing the same process as it does in investigating complaints filed under any provision contained in Title 54.1. Conduct of health care providers giving rise to disciplinary action shall be referred to the Board of Medicine for action consistent with the authority granted to the Board in §§ 54.1-2911 through 54.1-2928. If a notice or order is issued by the Board of Medicine, a copy shall be mailed to the claimant.

C. Upon receipt of the petition or the filing of a claim relating to the conduct of a participating hospital, the Department of Health shall investigate the petition or claim, utilizing the same process as it does in investigating complaints filed under any provision of Title 32.1. If it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, health care on the part of the hospital, it shall take any appropriate action consistent with the authority granted to the Department of Health in Title 32.1.

D. The deans of the schools of medicine of the Eastern Virginia Medical School, University of Virginia School of Medicine, and Medical College of Virginia of Virginia Commonwealth University shall develop a plan whereby each claim filed with the Board is reviewed by a panel of three qualified and impartial physicians drawn from a specialty appropriate to the facts of a particular case. Such plan shall provide that each of the three aforementioned medical schools shall maintain a review panel of physicians to review claims, with responsibility for reviewing claims rotating among each medical school's panel on a case-by-case basis. The chair of the panel shall be determined by the school's dean. The Board shall direct the Program to pay to the medical school that performed the assessment and prepared a report in conformity with this provision the sum of $3,000 per claim reviewed.

E. The panel created pursuant to subsection D shall prepare a report that provides a detailed statement of the opinion of the panel's members regarding whether the claimant's medical injury does or does not satisfy each of the criteria of a covered injury enumerated in such term's definition in § 38.2-6400. The report shall include the panel's basis for its determination of whether each such criterion was or was not satisfied. In addition, the report shall include such supporting documentation as the Board may reasonably request. The panel shall file its report with the Board 60 days from the date the petition was filed with the Board. At the same time that the panel files its report with the Board, the panel shall send copies thereof to the Program and all parties in the proceeding. At the request of the Board, at least one member of the panel shall be available to testify at the hearing conducted pursuant to § 38.2-6415. The Board shall consider, but shall not be bound by, the recommendation of the panel.

§ 38.2-6412. Furnishing copy of medical report.

A. Any hospital at which a medical incident has occurred, and any health care provider attending an injured patient, upon receipt of written request therefore by the injured patient, health care provider, insurer, or a certified rehabilitation provider as provided in Article 2 (§ 54.1-3510 et seq.) of Chapter 35 of Title 54.1 providing services to the injured patient, or of any legal representative thereof, promptly shall furnish a copy of all available medical records relating to the injured patient to such requestor, or to each of them.

B. As used in this section, the term "health care provider" shall have the same meaning as set forth in § 38.2-6400, except that state-operated facilities shall also be considered health care providers for the purposes of this section.

§ 38.2-6413. Physicians for medical examination.

The Board or any member thereof may, upon the application of either party or upon its own motion, appoint an impartial physician to make any necessary medical examination of the injured patient and to

testify in respect thereto. Such physician or surgeon shall be allowed travelling expenses and a reasonable fee to be fixed by the Board. The fees and expenses of such physician shall be paid by the Board.

§ 38.2-6414. Medical examination; physician-patient privilege inapplicable; autopsy.

A. After an injury and so long as he claims compensation, the injured patient, if so requested by the health care provider or ordered by the Board, shall submit himself to examination, at reasonable times and places, by an impartial physician designated and paid by the Board. However, no health care provider may obtain more than one examination per medical specialty without prior authorization from the Board, based upon a showing of good cause or necessity. The injured patient shall have the right to have present at such examination any duly qualified physician provided and paid by him. No fact communicated to, or otherwise learned by, any physician who may have attended or examined the injured patient, or who may have been present at any examination, shall be privileged.

B. If the injured patient refuses to submit himself to or in any way obstructs such examination, his right to compensation and his right to prosecute any proceedings under this chapter shall be suspended until such refusal or objection ceases and no compensation shall at any time be payable for the period of suspension unless in the opinion of the Board the circumstances justify the refusal or obstruction.

C. The health care provider or the Board may in any case of death require an autopsy at the expense of the party requesting the same. Such autopsy shall be performed upon order of the Board, and anyone obstructing or interfering with such autopsy shall be punished for contempt.

§ 38.2-6415. Hearing; award or opinion by Board.

A. Within a reasonable time following receipt of the report from the panel as provided in subsection E of § 38.2-6411, the Board shall set the date for a hearing, and shall notify the parties to the hearing of the time and place of the hearing. The parties to the hearing required under this section shall include the claimant and any health care provider identified in the petition filed pursuant to subsection A of § 38.2-6411.

B. Hearings convened by the Board shall be public proceedings.

C. At any hearing conducted under this section, the Board shall hear the parties at issue, their representatives, and witnesses; shall decide the issues in a summary manner; and shall make an award or opinion carrying out the decision. A copy of the award or opinion shall be sent immediately to the parties at issue by priority mail with delivery confirmation or equivalent mailing option. If any party at issue is represented by counsel, receipt of the award or opinion by counsel shall be deemed receipt by the party.

§ 38.2-6416. Interrogatories and depositions.

A. Any party to a proceeding under this chapter, upon application to the Board setting forth the materiality of the information requested, may serve interrogatories or cause the depositions of witnesses residing within or without the Commonwealth to be taken, the costs to be taxed as expenses incurred in connection with the filing of a claim. All interrogatories, depositions, or any other discovery shall conform to rules governing discovery promulgated by the Board.

B. The Board shall adopt rules governing discovery conforming as nearly as practicable to Part Four of the Rules of the Virginia Supreme Court. Such rules shall be adopted in accordance with and pursuant to the Administrative Process Act (§ 2.2-4000 et seq.).

§ 38.2-6417. Right to confront and cross-examine witnesses.

Upon a timely motion, all parties to a claim under this chapter shall have the right to confront and cross-examine witnesses. In pursuing that right, a party shall not be precluded from conducting depositions by oral examination or cross-examination at a hearing of any witnesses from whom evidence is elicited.

§ 38.2-6418. Determination of claims; presumption; finding of Board binding on participants; medical advisory panel.

A. The Board shall determine, on the basis of the evidence presented to it, whether the injury claimed is a covered injury as defined in § 38.2-6400 and, if so, how much compensation, if any, is awardable pursuant to § 38.2-6419.

B. If the Board determines (i) that the medical injury alleged is not a covered injury as defined in § 38.2-6400, it shall dismiss the petition and cause a copy of its order of dismissal to be sent immediately to the parties by registered or certified mail.

C. All parties are bound, for all purposes including any suit at law against a health care provider, by the finding of the Board, or any appeal therefrom, with respect to whether such medical injury is a covered injury.

§ 38.2-6419. Board awards for covered injuries; notice of award.

A. Upon determining that a claimant has sustained a covered injury, the Board shall make an award providing compensation for the following items relative to such injury:

1. Actual medically necessary and reasonable expenses of medical and hospital, rehabilitative,

therapeutic, nursing, attendant, residential and custodial care and service, medications, supplies, special equipment or facilities, and related travel, such expenses to be paid as they are incurred. However, such expenses shall not include:

a. Expenses for items or services that the claimant has received, or is entitled to receive, under the laws of any state or the federal government except to the extent prohibited by federal law;

b. Expenses for items or services that the claimant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity;

c. Expenses for which the claimant has received reimbursement, or for which the claimant is entitled to receive reimbursement, under the laws of any state or federal government except to the extent prohibited by federal law; and

d. Expenses for which the claimant has received reimbursement, or for which the claimant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

Expenses of medical and hospital services under this subdivision shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.

In order to provide coverage for expenses of medical and hospital services under this subdivision, the Board, in all cases where a comparative analysis of the costs, including the effects on the claimant's health insurance coverage, and benefits indicates that such action is more cost-effective than awarding payment of medical and hospital expenses, shall (i) require the claimant to purchase private health insurance providing coverage for such expenses, provided that the premium or other costs of such coverage shall be awarded by the Board; (ii) require the claimant to participate in the State Medicaid Program, the Children's Health Insurance Program, or other state or federal health insurance program for which the claimant is eligible; or (iii) if the Board determines that it would be unreasonably burdensome to require the claimant to purchase private health insurance and that the claimant is ineligible for a health insurance program described in clause (ii), make an award providing compensation for the cost of private accident and sickness insurance for the claimant;

2. Loss of earnings for the period that the covered injury renders a claimant unable to perform the functions of any job for which he was reasonably qualified at the date of the medical incident, based on his training and experience. Compensation for loss of earnings shall be paid in regular installments commencing on the date of the award, with the first payment covering the period from the date of the medical incident through the date of the award. If the claimant is an infant at the time the medical incident occurred, the Board's award for loss of earnings shall begin on the eighteenth birthday of the infant. An award for loss of earnings, for each week that such compensation is required by the terms of this subdivision, shall be in the amount of the average weekly wage in the Commonwealth determined as provided in § 65.2-500. Payments shall be calculated based on the Commonwealth's reporting period immediately preceding the date of the medical incident, and subsequently adjusted based upon the succeeding annual reports of the Commonwealth;

3. Permanent loss or disfigurement of the type described in subsection B of § 65.2-503 shall be compensated at the rate of 66 2/3 percent of the average weekly wage in the Commonwealth determined as provided in § 65.2-500 multiplied by the number of weeks specified for such loss or disfigurement in such subsection;

4. If the covered injury is the proximate cause of the death of a claimant, the Board (i) shall enter an award for burial expenses not exceeding $10,000 and reasonable transportation expenses for the deceased not exceeding $1,000 and (ii) in its discretion may make an award in an amount not exceeding $100,000 to the claimant's family. Prior to making an award pursuant to this section, the Board shall conduct a hearing for the purpose of determining whether such award is appropriate and, if so, the proper amount of such an award and how it should be paid, after receiving evidence pertaining to sorrow, mental anguish, solace, grief associated with the death of the claimant, and all other material factors that are relevant. The hearing may be conducted as part of a hearing conducted pursuant to § 38.2-6415. The same procedural requirements applicable to a hearing conducted pursuant to § 38.2-6415 shall apply to a hearing conducted hereunder. As used in this subdivision, a claimant's family means the injured patient's father, mother, or both, or if neither is a party to the proceeding, the injured patient's legal guardian;

5. Reasonable and necessary vocational rehabilitation services; however, the claimant shall not be entitled to services under this subdivision if he is not eligible for lawful employment. Vocational rehabilitation services may include vocational evaluation, counseling, job coaching, job development, job placement, on-the-job training, education, and retraining. Those vocational rehabilitation services that involve the exercise of professional judgment as defined in § 54.1-3510 shall be provided by a certified rehabilitation provider pursuant to Article 2 (§ 54.1-3510 et seq.) of Chapter 35 of Title 54.1 or by a person licensed by the Boards of Counseling; Medicine; Nursing; Optometry; Psychology; or Social Work or, in accordance with subsection B of § 54.1-3513, by a person certified by the Commission on

Rehabilitation Counselor Certification as a certified rehabilitation counselor or a person certified by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists as a Certified Vocational Evaluation Specialist. Such services shall take into account the injured patient's preinjury employment, if any, and wage classifications; his age, aptitude, and level of education; the likelihood of success in the new vocation; and the relative costs and benefits to be derived from such services. The unjustified refusal of a claimant to accept vocational rehabilitation services when provided pursuant to this subsection shall bar the injured patient from further compensation until such refusal ceases and no compensation shall at any time be paid for the period of suspension unless, in the opinion of the Board, the circumstances justified the refusal. In any such case the Board may order a change in the vocational rehabilitation services; and

6. Reasonable expenses incurred in connection with the filing of a claim under this chapter, including reasonable attorney fees, which shall be subject to the approval and award of the Board as provided in § 38.2-6433.

B. The total amount that the Board may award under this section to compensate an injured patient for any covered injury shall not exceed $2 million.

C. An award under this section shall not include, and an injured patient sustaining a medical injury shall not be entitled to recover in any proceeding, compensation for pain and suffering or other non-economic damages, punitive damages, or any other damages, however characterized, for which payment is not authorized in subsection A.

D. A copy of the award shall be sent immediately by registered or certified mail to the parties.

§ 38.2-6420. Injuries in different medical incidents; injury to individual with disability; subsequent permanent injury by medical incident.

If an injured patient has sustained a covered injury for which he has received an award under § 38.2-6419 and receives a subsequent covered injury, he shall be entitled to compensation in a hearing for such later covered injury only for the portion of his injuries that would have resulted from the later covered injury if the earlier covered injury had not occurred.

§ 38.2-6421. Compensation to injured patient's distributees upon his death from any other cause.

When an injured patient receives or is entitled to compensation under this chapter for a covered injury and dies from a cause other than the covered injury, payment of the unpaid balance of compensation shall be made to his statutory dependents under this chapter, in lieu of the compensation the injured patient would have been entitled to had he lived. However, if the death is due to a covered injury for which an award may be made as provided in subdivision A 4 of § 38.2-6419, all right to unpaid compensation provided by this section shall terminate.

§ 38.2-6422. Time of payment.

A. The Board, upon application of a party, in its discretion, having regard to the welfare of the injured patient and the convenience of the health care provider, may authorize compensation to be paid bi-weekly, monthly, or quarterly instead of weekly.

B. If any payment is not paid within two weeks after it becomes due, there shall be added to such unpaid compensation an amount equal to 20 percent thereof, unless the Board finds that any required payment has been made as promptly as practicable and there is good cause outside the control of the health care provider for the delay. No such penalty shall be added, however, to any payment made within two weeks after the expiration of (i) the period in which Board review may be requested pursuant to § 38.2-6428 or (ii) the period in which a notice of appeal may be filed pursuant to § 38.2-6429.

§ 38.2-6423. Lump sum payments.

When the parties agree and the Board deems it to be to the best interests of the injured patient or his dependents, or when it will prevent undue hardships on the health care provider, or his insurance carrier, without prejudicing the interests of the injured patient or his dependents, liability for compensation may be redeemed, in whole or in part, through payment by the health care provider of a lump sum, which shall be fixed by the Board.

§ 38.2-6424. Who may receive payment and receipt therefor.

A. Whenever payment is made to any person 18 years of age or over, the written receipt of such person shall acquit the health care provider. If a minor shall be entitled to receive a lump sum payment amounting to not more than $15,000 as compensation for injuries, or as a distributive share by virtue of this chapter, the parent or natural guardian upon whom such minor shall be dependent for support shall be authorized and empowered to receive and give receipt for such moneys to the same extent as a guardian of the person and property of such minor duly appointed by proper court, and the release or discharge of such parent or natural guardian shall be a full and complete discharge of all claims or demands of such minor thereunder.

B. Whenever any lump sum payment greater than $15,000 is due to a minor or to an incapacitated person as defined in § 37.2-1000, the same shall be made to the guardian of the property of such minor or the conservator of such incapacitated adult or, if there is none, to some suitable person or

corporation appointed by the circuit court as a trustee, and the receipt of such trustee shall acquit the health care provider.

§ 38.2-6425. When injured patient's rights exercised by guardian or trustee.

Any claim authorized by this chapter may be filed by any legal representative on behalf of an injured patient who is incapacitated or is under 18 years of age at the time when any right or privilege accrues to him under this chapter. In the case of a deceased injured patient, the claim may be filed by an administrator, executor, or other legal representative.

§ 38.2-6426. Liability of multiple health care providers.

Whenever any injured patient for whose injury or death compensation is payable under this chapter shall have sustained a covered injury as a result of the delivery of medical services by two or more health care providers, such health care providers shall contribute to the payment of such compensation in proportion to their liability for the covered injury, as determined by the Board. However, nothing in this section shall prevent any reasonable arrangement between such health care providers for a different distribution as between themselves of the ultimate burden of compensation.

§ 38.2-6427. Assignments of compensation; exemption from creditors' claims.

A. No claim for compensation under this chapter shall be assignable. All compensation and claims therefor shall be exempt from all claims of creditors, even if the compensation is deposited into an account with a financial institution and is thereby commingled with other funds. However, benefits paid in compensation or in compromise of a claim for compensation under this chapter shall be subject to claims for spousal and child support subject to the same exemptions allowed for earnings in § 34-29.

B. Upon an order of garnishment, attachment, or other levy addressed to a financial institution in which the principal defendant claims to have exempt funds hereunder, the principal defendant may file an answer asserting the exemption hereunder. From the time of service of such garnishment, attachment, or levy, the financial institution, until further order of the court, shall hold the amount subject to such garnishment, attachment, or levy, or such lesser amount or sum as it may have, which amount shall be set forth in its answer. It shall hold such amount free of any person drawing against such funds whether by check against such account or otherwise. The financial institution shall be subject to such further order or subpoena for discovery of its records, for which it shall be entitled an order or agreement for compensation for the expense of such service, and in a case deemed appropriate to the court by such an order directing deposit of funds or further security prior to such records being ordered produced.

§ 38.2-6428. Rehearing on Board determination or award.

If an application for review is made to the Board within 20 days from the date of a determination pursuant to § 38.2-6418, or within 20 days from the date of an award by the Board pursuant to § 38.2-6419, the full Board, excluding any member of the Board who made the determination or award, if the first hearing was not held before the full Board, shall review the evidence. If deemed advisable and as soon as practicable, the Board instead may hear the parties, their representatives, and witnesses and shall make a determination or award, as appropriate. Such review or determination, together with a statement of the findings of fact, rulings of law, and other matters pertinent to the questions at issue, shall be filed with the record of the proceedings and shall be sent immediately to the parties.

§ 38.2-6429. Conclusiveness of determination or award; appeal.

A. The determination of the Board pursuant to § 38.2-6418, or the award of the Board, as provided in § 38.2-6419, if not reviewed within the time prescribed by § 38.2-6428, or a determination or award of the Board upon such review, as provided in § 38.2-6428, shall be conclusive and binding as to all questions of fact. No appeal shall be taken from the decision of one member of the Board until a review of the case has been held before the full Board, as provided in § 38.2-6428. Appeals shall lie from the full Board to the Court of Appeals in the manner provided in the Rules of the Supreme Court.

B. The notice of appeal shall be filed with the clerk of the Board within 30 days from the date of such determination or award or within 30 days after receipt by registered or certified mail of such determination or award whichever occurs last. A copy of the notice of appeal shall be filed in the office of the clerk of the Court of Appeals as provided in the Rules of the Supreme Court.

C. Cases so appealed shall be placed upon the privileged docket of the Court and be heard at the next ensuing term thereof. In case of an appeal from an award of the Board to the Court of Appeals, the appeal shall operate as a suspension of the award, and the Program shall not be required to make payment of the award involved in the appeal until the questions at issue therein shall have been fully determined in accordance with the provisions of this chapter.

§ 38.2-6430. Interest on appealed award.

An award entered by the Board shall take effect on the date of entry. To the extent that any payment due under an award is delayed beyond its due date by reason of an appeal to the full Board or an appellate court, payments so delayed shall bear interest at the judgment rate as provided in § 6.1-330.54.

§ 38.2-6431. Enforcement of orders and awards.

Orders or awards of the Board may be recorded, enforced, and satisfied as orders or decrees of a

circuit court upon certification of such order or award by the Board. The Board shall certify such order or award upon satisfactory evidence of noncompliance with the same.

§ 38.2-6432. Costs when health care provider or insurer acts unreasonably or delays payment.

A. If the Board or any court before whom any proceedings are brought or defended by the health care provider or insurer under this chapter shall determine that such proceedings have been brought, prosecuted, or defended without reasonable grounds, it may assess against the health care provider or insurer who has so brought, prosecuted, or defended them the whole cost of the proceedings, including a reasonable attorney fee, to be fixed by the Board.

B. Where the Board finds that a health care provider or insurer has delayed payment without reasonable grounds, it may assess against the health care provider or insurer the whole cost of the proceedings, including a reasonable attorney fee to be fixed by the Board. In such a case where an attorney fee is awarded against the health care provider or insurer, the Board shall calculate and add to any award made to the claimant interest at the judgment rate, as set forth in § 6.1-330.54, on the benefits accrued from the date the Board determined the award should have been paid through the date of the award.

C. Where the Board finds that a health care provider or insurer has filed an application for a hearing in bad faith, it shall assess against the health care provider or insurer an amount up to 10 percent of the total amount of the benefits accrued from the date the Board determined the award should have been paid through the date of the award. This payment shall be in addition to any costs, fees, or awards as set forth in subsection B.

§ 38.2-6433. Expenses and fees.

Reasonable expenses incurred in connection with the filing of a claim under this chapter, including fees of attorneys and physicians and charges of hospitals for services, whether employed by a health care provider, claimant, or insurance carrier under this chapter, shall be subject to the approval and award of the Board. The Board shall have exclusive jurisdiction over all disputes concerning such fees or charges and may order the repayment of the amount of any fee which has already been paid that it determines to be excessive. Appeals from any Board determinations on such fees or charges shall be taken as provided in § 38.2-6429.

§ 38.2-6434. Providing written information.

Whenever, in the course of proceedings in connection with awards, the Board issues any written notice, opinion, order, or award regarding a specific case, the Board shall provide copies to the claimant, the health care provider, and the insurance carrier, and, if represented, their counsel, at the same time.

§ 38.2-6435. Lien against settlement proceeds or verdict in third-party suit; subrogation of health care provider to injured patient's rights against third parties; evidence; recovery; compromise.

A. A claim against a health care provider under this chapter shall create a lien on behalf of the health care provider against any verdict or settlement arising from any right to recover damages that the injured patient, his personal representative, or other person may have against any other party for the covered injury, and such health care provider also shall be subrogated to any such right and may enforce, in his own name or in the name of the injured patient or his personal representative, the legal liability of such other party. The amount of compensation paid by the health care provider or the amount of compensation to which the injured patient or his dependents are entitled shall not be admissible as evidence in any action brought to recover damages.

B. Any amount collected by the health care provider under the provisions of this section in excess of the amount paid by the health care provider or for which he is liable shall be held by the health care provider for the benefit of the claimant or other person entitled thereto, less a proportionate share of such amounts as are paid by the health care provider for reasonable expenses and attorney fees.

C. No compromise settlement shall be made by the health care provider in the exercise of such right of subrogation without the approval of the Board and the claimant or the personal representative or dependents of the deceased injured patient being first obtained.

D. If a claimant or a person acting on behalf of the injured patient receives the proceeds of the settlement or verdict and the health care provider's lien pursuant to subsection A has not been satisfied, the health care provider shall have the right to recover its lien either as a credit against future benefits or through a civil action against the person who received the proceeds.

§ 38.2-6436. Protection of health care provider when injured patient sues third party.

In any action by an injured patient, his personal representative, or other person against any person other than the health care provider, the court shall, after reasonable notice to the parties and the health care provider, ascertain the amount of compensation paid and expenses for medical, surgical, and hospital attention and supplies, and funeral expenses incurred by the health care provider under the provisions of this chapter, and deduct therefrom a proportionate share of such amounts as are paid by the plaintiff for reasonable expenses and attorney fees. In event of judgment against such person other

than the health care provider, the court shall in its discretion order that the judgment debtor pay such compensation and expenses of the health care provider, less said share of expenses and attorney fees, so ascertained by the court out of the amount of the judgment, so far as sufficient, and the balance, if any, to the judgment creditor.

§ 38.2-6437. Expenses and attorney fees in action under § 38.2-6435 or § 38.2-6436.

A. Except as provided in subsection B, in any action, or claim for damages, by an injured patient, his personal representative, or other person against any person other than the health care provider, and in any such action brought, or claim asserted, by the health care provider under his right of subrogation provided for in § 38.2-6435, if a recovery is effected, either by judgment or voluntary settlement, the reasonable expenses and reasonable attorney fees of such claimants shall be apportioned pro rata between the health care provider and the injured patient, his personal representative, or other person, as their respective interests may appear.

B. If the health care provider is required to institute an action against any party to recover some or all of its lien pursuant to subsection D of § 38.2-6435, the health care provider shall not be required to pay any share of the reasonable expenses and reasonable attorney fees associated with that portion of its lien that is not preserved by the injured patient, his personal representative, or other person.

§ 38.2-6438. False statements, representations in connection with an award; penalties.

A. It shall be unlawful for any person to knowingly make, file, or use any writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry in connection with an award under this chapter. It shall also be unlawful for any person to aid or abet another in a violation of this section.

B. A violation of this section shall be punishable as a Class 1 misdemeanor.

C. Any person convicted of a violation of this section who is licensed to practice any of the healing arts as defined in § 54.1-2900 or to practice law pursuant to Chapter 39 (§ 54.1-3900 et seq.) of Title 54.1, and who committed the violation while engaged in such practice, may have such license suspended or revoked in accordance with the provisions of Chapter 29 (§ 54.1-2900 et seq.) and Chapter 39 (§ 54.1-3900 et seq.) of Title 54.1, respectively.

D. Venue for the prosecution of a violation of this section shall lie in the county or city wherein the injury occurred.

§ 38.2-6439. Duty to insure payment of compensation; effect of insurance.

A. Except as provided in subsection C, every health care provider shall insure the payment of compensation to injured patients by obtaining and maintaining a policy of medical incident insurance with limits per occurrence in the maximum amount of liability established in subsection B of § 38.2-6419, that is issued by an insurer authorized to transact the business of medical incident insurance in the Commonwealth. While such insurance remains in force, a health care provider and those conducting his business shall only be liable to an injured patient for personal injury or death by covered injury to the extent and in the manner herein specified.

B. As used in this section, the words "those conducting his business" shall include any person whose act results in an injury or death compensable under this chapter and arises out of and in the course of employment by a health care provider who is or may be liable for the payment of compensation.

C. Upon proper certification to the Program, the following physicians shall be exempt from the requirement of this chapter that they maintain a policy of medical incident insurance:

1. A physician who is employed by the Commonwealth or federal government and whose income from professional fees is less than an amount equal to 10 percent of the annual salary of the physician;

2. A physician who is enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education;

3. A physician who has retired from active clinical practice; or

4. A physician whose active clinical practice is limited to the provision of services, voluntarily and without compensation, to any patient of any clinic that is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106.

§ 38.2-6440. Evidence of compliance with chapter; notices of cancellation of insurance.

A. Each health care provider subject to this chapter shall file with the Board, in form prescribed by it, annually or as often as may be necessary, evidence of his compliance with the provisions of subsection A of § 38.2-6439 and all others relating thereto; however, any health care provider may have his insurance carrier make such filing. Evidence of a health care provider's compliance with the provisions of subsection A of § 38.2-6439 shall be deemed to satisfy such provisions if it includes the name and address of the insured, his policy number, dates of insurance coverage, the name and address of his insurer, and the insurer's identification number. Proof of coverage information filed with the Board by an insurance carrier or rate service organization on behalf of a health care provider shall in no event be aggregated by the Board with the proof of coverage information filed by or on behalf of other health care providers. Every health care provider who has complied with the foregoing provision and has subsequently cancelled his insurance shall immediately notify the Board of such cancellation,

the date thereof, and the reasons therefor. Every insurance carrier shall in like manner notify the Board immediately upon the cancellation of any policy issued by it, except that a carrier need not set forth its reasons for cancellation unless requested by the Board.

B. No policy of insurance hereafter issued under the provisions of this chapter shall be cancelled or nonrenewed by the insurer issuing such policy except on 30 days' notice to the health care provider and the Board, unless the health care provider has obtained other insurance and the Board is notified of that fact by the insurer assuming the risk, or unless, in the event of cancellation, said cancellation is for nonpayment of premiums; then 10 days' notice shall be given the health care provider and the Board.

C. The Board may designate an agent for receipt of any notices required to be given to it pursuant to this section.

§ 38.2-6441. Civil penalty for violation of duty to insure.

A. If such health care provider fails to comply with the provisions of § 38.2-6439, he shall be assessed a civil penalty of not less than $500 nor more than $5,000, and he shall be liable during continuance of such failure to any injured patient either for compensation under this chapter or at law in a suit instituted by the injured patient against such health care provider to recover damages for personal injury or death due to the negligence of the health care provider.

B. The civil penalties herein provided may be assessed by the Board in an open hearing with the right of review and appeal as in other cases. Upon a finding by the Board of such failure to comply, and after 15 days' written notice thereof sent by certified mail to the health care provider, if such failure continues, the Board may order the health care provider to cease and desist all business transactions and operations until found by the Board to be in compliance with the provisions of this chapter.

C. Any civil penalty assessed pursuant to this section shall be paid into the Uninsured Provider's Fund established in § 38.2-6462.

§ 38.2-6442. Criminal penalties.

In addition to the civil penalties assessed pursuant to § 38.2-6441, any health care provider who knowingly and intentionally fails to comply with the provisions of § 38.2-6439 is guilty of a Class 2 misdemeanor.

§ 38.2-6443. Constructive notice to, jurisdiction of, and awards, binding upon insurer.

All policies of medical incident insurance shall contain clauses to the effect that (i) as between the health care provider and the insurer, notice to or knowledge of the occurrence of the injury on the part of the insured health care provider shall be deemed notice or knowledge on the part of the insurer, (ii) jurisdiction of the insured for the purposes of this chapter shall be jurisdiction of the insurer, and (iii) the insurer shall in all things be bound by and subject to the awards, judgments, or decrees rendered against such insured health care provider.

§ 38.2-6444. How formal notice may be given.

Whenever by this chapter or the terms of any policy contract notice is required to be given by a health care provider to any insurance carrier, the same may be given by delivery or by mailing by registered letter properly addressed and stamped to the principal office or chief agent of such insurance carrier within this Commonwealth or to its home office, or to the secretary, general agent, or chief officer thereof in the United States.

§ 38.2-6445. Liability of insurer.

No policy of medical incident insurance shall be issued unless it contains the agreement of the insurer that it will promptly pay the person entitled to the same all benefits conferred by this chapter and all installments of the compensation that may be awarded or agreed upon and that the obligation shall not be affected by any default of the insured after the injury or by any default in giving notice required by such policy or otherwise. Such agreement shall be construed to be a direct promise by the insurer to the person entitled to compensation, enforceable in his name.

§ 38.2-6446. Subrogation of insurance carrier to provider's rights; compromise.

When any health care provider is insured against liability for covered injuries with an insurance carrier, and such insurance carrier shall have paid any compensation for which the health care provider is liable or shall have assumed the liability of the health care provider therefor, it shall be subrogated to all the rights and duties of the health care provider and may enforce any such rights in its own name or in the name of the injured patient or his personal representative; however, nothing herein shall be construed as conferring upon the insurance carrier any other or further rights than those existing in the health care provider at the time of the injury to his injured patient, anything in the policy of insurance to the contrary notwithstanding. No compromise settlement shall be made by the insurance carrier in the exercise of such right of subrogation without the approval of the Board and the injured patient or the personal representative or dependents of the deceased individual being first obtained.

§ 38.2-6447. Insurance deemed subject to chapter; approval of forms.

Every policy of medical incident insurance shall be subject to the provisions of this chapter. No corporation, association, or organization shall enter into any such policy of insurance unless its form shall have been approved by the Commission.

§ 38.2-6448. Insurer to furnish written evidence of coverage on request.

Upon request of its insured, every insurer issuing a policy of medical incident insurance shall furnish to such insured, within five working days of receipt of said request, a certificate or other writing evidencing the effective coverage afforded such insured. Any insurer violating the provisions of this section shall be punished by a fine of $500.

§ 38.2-6449. Rates; cooperation between Commission and Board.

The Commission shall make such arrangements with the Board as may be agreeable to the Board, for collecting, compiling, preserving, and publishing statistical and other data in connection with the work of regulating insurance rates and for the division of the expenses thereof, to the end that duplication of work and expenditures may be avoided. Whenever it deems proper, with the consent of the Board, the Commission may appoint members of the Board, or its employees, as special agents of the Commission to take testimony and make reports with reference to any matter involving questions of medical incident liability insurance rates.

§ 38.2-6450. Minimum standards of service for insurers.

The Commission in cooperation with the Board shall establish minimum standards of service for insurers writing medical incident insurance policies in this Commonwealth, including but not limited to the servicing of such policies, the establishment of offices within the Commonwealth, and the payment of compensation.

§ 38.2-6451. Penalty for violation of certain provisions.

Any person or persons who shall in this Commonwealth (i) act or assume to act as agent for any such insurance carrier whose authority to do business in this Commonwealth has been suspended, while such suspension remains in force, (ii) fail to comply with requirements or standards imposed under §§ 38.2-6449 and 38.2-6450, or (iii) willfully make a false or fraudulent statement of the business or condition of any such insurance carrier, or a false or fraudulent return as therein provided, shall be deemed guilty of a misdemeanor and, upon conviction, shall be punished by a fine of not less than $100 nor more than $1,000 or by imprisonment for not less than 10 nor more than 90 days, or both such fine and imprisonment, in the discretion of the court or jury trying the case.

§ 38.2-6452. Application to Commission for assignment of risk; insurer assigned risk to issue policy.

Every health care provider who has been unable to obtain a medical incident insurance policy shall have the right to apply to the Commission to have his risk assigned to an insurance carrier licensed to write and writing medical incident liability insurance in this Commonwealth. The insurance carrier, whether stock, mutual, reciprocal, or interinsurer or other type or form of organization, to whom any such risk is assigned shall issue a policy of medical incident insurance that will enable such health care provider to meet the requirements of this chapter.

§ 38.2-6453. Commission to make rules and regulations, and establish rating schedules and rates.

A. The Commission may make reasonable rules and regulations for the assignment of risks to insurance carriers. It shall establish such rate classifications, rating schedules, rates, rules, and regulations to be used by insurance carriers issuing assigned risk medical incident insurance policies in accordance with this chapter as appear to it to be proper.

B. In the establishment of rate classifications, rating schedules, rates, rules, and regulations, it shall be guided by such principles and practices as have been established under its statutory authority to regulate medical incident insurance rates and it may act in conformity with its statutory discretionary authority in such matters.

§ 38.2-6454. Action by Commission upon application.

The Commission may, if in its judgment it deems such action to be justified after reviewing all information pertaining to the applicant or policyholder available from its records, the records of the Board, or other sources:

1. Refuse to assign an application;

2. Approve the rejection of an application by an insurance carrier;

3. Approve the cancellation of a medical incident insurance policy by an insurance carrier; or

4. Refuse to approve the renewal or the reassignment of an expiring policy.

§ 38.2-6455. Information filed with Commission by insurance carrier to be confidential; exception.

Any and all information filed with the Commission by an insurance carrier or a rate service organization in connection with an assigned risk shall be confidential and solely for the information of the Commission and its staff and shall not be disclosed to any person, including an applicant, policyholder, and any other insurance carrier. However, at the discretion of the Commission, such information may be disclosed to any agent or insurer licensed in the Commonwealth for the purpose of procuring coverage in the voluntary market. Such disclosure shall be limited to the insured's name, address, policy expiration, premium, information pertaining to whether the insured has locations in

multiple states, and any other information the Commission deems appropriate.

§ 38.2-6456. Disclosures not required of Commission; liability for acts or omissions.

A. The Commission shall not be required to disclose to any person, including the applicant or policyholder, its reasons for:

1. Refusing to assign an application;

2. Approving the rejection of an application by an insurance carrier;

3. Approving the cancellation of a medical incident insurance policy by an insurance carrier; or

4. Refusing to approve the renewal or the reassignment of an expiring policy.

B. The Commission shall not nor shall anyone acting for it be held liable for any act or omission in connection with the administration of the duties imposed upon it by the provisions of this chapter, except upon proof of actual malfeasance.

§ 38.2-6457. Records and reports of medical incidents.

A. Every health care provider shall keep a record of all medical incidents that occur in the course of providing medical treatment. Within 10 days after the occurrence of such medical incident, and knowledge of covered injury, a report of the injury or death shall be made and transmitted to the Board by the health care provider, its representative, or its insurance carrier, in accordance with regulations adopted by the Board, which may authorize the transmission of such reports in written, magnetic, electronic, or facsimile media. The Board shall provide forms and instructions for reporting as required by this section. The Board shall provide the Board of Medicine with such reports.

B. The medical incident report shall contain the name, nature, and location of the business of the health care provider and the name, age, sex, and wages and occupation of the injured patient, and shall state the date and hour of the medical incident causing the medical injury and the nature and cause of the injury, together with such other information as may be required by the Board. However, those injuries deemed minor by the Board shall be reported in the manner prescribed by the Board.

§ 38.2-6458. Failure to make required reports; civil penalty.

A. Any health care provider who fails to make any report required by the Board pursuant to § 38.2-6457 shall be assessed a civil penalty of not more than $500 for each failure. If the Board determines that any such failure is willful, it shall assess a civil penalty of not less than $500 and not more than $5,000. The civil penalty herein provided may be assessed by the Board in an open hearing with the right of review and appeal as in other cases. In the event the health care provider has transmitted the report to the insurance carrier for transmission to the Board, the insurance carrier failing to transmit the report shall be liable for the civil penalty.

B. Any civil penalty assessed pursuant to this section shall be paid into the Uninsured Provider's Fund established pursuant to § 38.2-6462.

§ 38.2-6459. Records not public.

A. The records of the Board, insofar as they refer to medical incidents, covered injuries, and settlements, shall not be open to the public but only to the parties satisfying the Board of their interest in such records and their right to inspect them; however, the Board shall make its records about an injured patient available to the Board of Medicine, Virginia Employment Commission, the Department of Social Services, or the Virginia Retirement System if any such entity requests such records.

B. The following records of the Board shall be confidential: (i) records subject to the attorney-client privilege; (ii) medical and mental records of claimants obtained by the Board; (iii) records concerning deliberations of the Board in connection with specific claims; (iv) reports of expert witnesses retained by the Board that have not become part of the record before the Board; and (v) all records required to be kept confidential by federal law. Except as herein authorized, an officer, agent, or employee of the Board, and any person who has held any such position, shall not disclose, directly or indirectly, any such confidential record or information.

§ 38.2-6460. Tax for administrative fund.

A. For the purpose of paying the salaries and necessary expenses of the Board and its assistants and employees in administering and carrying out the provisions of this chapter, an administrative fund shall be created and maintained in the following manner:

1. All insurance carriers licensed to write and engaged in writing liability insurance in the Commonwealth of a particular year shall pay into the fund an assessment for the following year, in an amount determined by the Commission but which shall not exceed the rate of 2.5 percent of the amount of such premiums. Liability insurance for the purposes of this section shall include medical incident insurance and the classes of insurance defined in §§ 38.2-117, 38.2-118, and 38.2-119 and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125, 38.2-130, 38.2-131, and 38.2-132.

2. All annual assessments against liability insurance carriers shall be made on the basis of net direct premiums written in the Commonwealth during the prior year ending December 31, as reported to the Commission, and shall be in the proportion that the net direct premiums written by each bears to the aggregate net direct premiums written in this Commonwealth by all such entities. For purposes of this

chapter "net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

3. Liability insurance carriers shall be entitled to recover their initial and annual assessments through (i) a surcharge on future policies, (ii) a rate increase applicable prospectively, or (iii) a combination of the two, at the discretion of the Commission.

4. Every such insurance carrier shall, for the 12 months ending December 31 of each year, make a return verified by the affidavits of its president and secretary, or other chief officers or agents, to the Board stating the amount of such premiums and credits during the period covered by such return. The Commission shall have access at all times to the records so filed with the Board by such insurance carriers and may require such additional information as the Commission deems necessary for the performance of the duties herein conferred upon it.

B. If any such insurance carrier shall fail or refuse to make the return required by this chapter, the Commission shall assess the tax against such insurance carrier at the rate herein provided for, on such amount of premiums as it may deem just, and the proceedings thereon shall be the same as if the return had been made.

C. If any such insurance carrier shall withdraw from business in this Commonwealth before the tax shall fall due, as herein provided, or shall fail or neglect to pay such tax, the Comptroller shall at once proceed to collect the same and may employ such legal process as may be necessary for that purpose, and when so collected he shall pay the same into the state treasury. The suit may be brought by the Comptroller, in his official capacity, in any court of this Commonwealth having jurisdiction. A reasonable attorney fee may be taxed as costs therein and process may issue to any county of the Commonwealth and may be served as in civil actions, or in the case of an unincorporated association, partnership, interindemnity contract, or other plan or scheme, upon any agent of the parties thereto upon whom process may be served under the laws of this Commonwealth.

D. Any insurance carrier liable to pay a tax upon premiums under this chapter shall not be liable to pay any other or further tax upon such premiums, or on account thereof, under any other law of this Commonwealth, except as provided in §§ 65.2-1101 and 65.2-1201 and Chapter 4 (§ 38.2-400 et seq.).

§ 38.2-6461. Disposition of fund; excess funds.

A. Upon receiving the payments required by § 38.2-6460, the Comptroller shall place the whole thereof to the credit of the fund for the administration of this chapter. Such fund shall not be used for any other purpose, except as hereinafter expressly provided. The Board shall administer the fund to carry out the provisions of this chapter and shall disburse the same as hereinafter directed. If the receipts shall exceed the expenditures for any year and a surplus accrue in the fund in excess of one year's budgeted expenditures, the Board shall authorize a credit for the ensuing years as provided by subsection B. No portion of the fund or any surplus accruing therein shall be paid into the general fund of the state treasury, nor shall the fund be administered, handled, or disbursed except as provided in this section. All claims for salaries or expenses, when approved by a majority of the members of the Board, shall be presented to the Comptroller and audited by him under the provisions of Chapter 8 (§ 2.2-800 et seq.) of Title 2.2, and he shall draw his disbursement warrants therefor on the State Treasurer; however, any claim for $2,000 or less may be approved by the Chairman or his designee. All such claims shall show to whom and for what service, material, or other things or reason such amounts are to be paid and shall be accompanied by voucher, checks, or receipts covering the same, except as to items of less than one dollar.

B. If it be ascertained that the tax collected exceeds the total chargeable against the maintenance fund under the provisions of this chapter, the Board shall authorize a corresponding credit upon the collection for any year or make refunds of taxes collected in such amounts as are necessary to maintain a fund balance not exceeding one year's budgeted expenditures.

§ 38.2-6462. Uninsured Provider's Fund created; financing tax.

A. There is hereby created a fund to be known as the "Uninsured Provider's Fund" to be administered, maintained, and disbursed by the Board as hereinafter provided.

B. For the purpose of providing funds for compensation benefits awarded against any uninsured health care provider under any provision of this chapter, a tax not to exceed one-fourth of one percent shall be assessed, collected, and paid into the state treasury by the same persons and in the same manner as set forth in § 38.2-6460.

C. This tax shall be in addition to the tax for the Board's administrative fund and shall be held by the Comptroller of the Commonwealth solely for the payment of awards against such fund.

D. At the end of any calendar year in which the Uninsured Provider's Fund has to its credit a sum in excess of the next year's budgeted expenditures, the tax shall be suspended for the ensuing calendar year.

§ 38.2-6463. Defense of claims against fund by Attorney General.

Upon being notified by the Board that a claim is pending before it against a health care provider

who has not complied with the provisions of § 38.2-6439, or is exempt pursuant to subsection C of § 38.2-6439, the Attorney General or his designee may, in his discretion, appear before the Board and defend any claim against the Uninsured Provider's Fund. A decision on the part of the Attorney General not to appear shall be made only after consultation with the Board. With the leave of the Board, the Attorney General may enter an appearance in a claim at any stage of the proceedings if he determines that the position of the fund needs to be protected.

§ 38.2-6464. Awards from Uninsured Provider's Fund.

A. Whenever, following due investigation of a claim for benefits under this chapter, the Board determines that (i) the health care provider of record has failed to comply with the requirements of § 38.2-6439 and (ii) the claim is compensable, the Board shall make a provisional award of compensation benefits, or any unpaid balance thereof, without further delay. Thereafter, the Board shall make a final award concerning such benefits or unpaid balance thereof, in accordance with the provisions of this chapter. The Board shall order payment of any award of compensation benefits pursuant to this chapter from the Uninsured Provider's Fund.

B. After an award has been entered against a health care provider for compensation benefits under any provision of this chapter, and upon finding that the health care provider has failed to comply with the provisions of § 38.2-6439, the Board shall order the award, or any unpaid balance, to be paid from the Uninsured Provider's Fund after demand has been made by a claimant upon his health care provider or other uninsured entity that is responsible to pay the award. Such demand may be waived by the Board for good cause shown.

§ 38.2-6465. Subrogation and recoupment.

A. The Board shall, upon payment of a claim from the Uninsured Provider's Fund, be subrogated to any right to recover damages that the injured patient or his personal representative or any other person may have against his health care provider or any other party for a covered injury.

B. The Board shall, on behalf of the Uninsured Provider's Fund, refer any unsatisfied claim against an uninsured health care provider to the Attorney General for collection.

§ 38.2-6466. Payments procured by fraud or mistake; recovery.

Any payment to a claimant pursuant to this chapter that is later determined by the Board to have been procured by fraud or mistake shall be recovered from the claimant and credited to the Uninsured Provider's Fund.

§ 38.2-6467. Immunity for certain health professionals and health profession students serving as members of certain entities.

A. For the purposes of this subsection, "health professional" means any clinical psychologist, applied psychologist, school psychologist, dentist, certified emergency medical services personnel, licensed professional counselor, licensed substance abuse treatment practitioner, certified substance abuse counselor, certified substance abuse counseling assistant, licensed marriage and family therapist, nurse, optometrist, pharmacist, physician, chiropractor, podiatrist, or veterinarian who is actively engaged in the practice of his profession or any member of the Health Practitioners' Monitoring Program Committee pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of Title 54.1.

Unless such act, decision, or omission resulted from such health professional's bad faith or malicious intent, any health professional, as defined in this subsection, shall be immune from liability under this chapter for any act, decision, or omission resulting from his duties as a member or agent of any entity that functions primarily (i) to investigate any complaint that a physical or mental impairment, including alcoholism or drug addiction, has impaired the ability of any such health professional to practice his profession and (ii) to encourage, recommend, and arrange for a course of treatment or intervention, if deemed appropriate, or (iii) to review or monitor the duration of patient stays in health facilities, delivery of professional services, or the quality of care delivered in the statewide emergency medical care system for the purpose of promoting the most efficient use of available health facilities and services, the adequacy and quality of professional services, or the reasonableness or appropriateness of charges made by or on behalf of such health professionals. Such entity shall have been established pursuant to a federal or state law, or by one or more public or licensed private hospitals, or a relevant health professional society, academy, or association affiliated with the American Medical Association, the American Dental Association, the American Pharmaceutical Association, the American Psychological Association, the American Podiatric Medical Association, the American Society of Hospitals and Pharmacies, the American Veterinary Medical Association, the American Association for Counseling and Development, the American Optometric Association, the International Chiropractic Association, the American Chiropractic Association, the NAADAC, the Association for Addiction Professionals, the American Association for Marriage and Family Therapy, or a governmental agency.

B. For the purposes of this subsection, "health profession student" means a student in good standing who is enrolled in an accredited school, program, or curriculum in clinical psychology, counseling, dentistry, medicine, nursing, pharmacy, chiropractic, marriage and family therapy, substance abuse

treatment, or veterinary medicine and has received training relating to substance abuse.

Unless such act, decision, or omission resulted from such health profession student's bad faith or malicious intent, any health profession student, as defined in this subsection, shall be immune from liability under this chapter for any act, decision, or omission resulting from his duties as a member of an entity established by the institution of higher education in which he is enrolled or a professional student's organization affiliated with such institution that functions primarily (i) to investigate any complaint of a physical or mental impairment, including alcoholism or drug addiction, of any health profession student and (ii) to encourage, recommend, and arrange for a course of treatment, if deemed appropriate.

C. The immunity provided hereunder shall not extend to any person with respect to actions, decisions, or omissions, liability for which is limited under the provisions of the federal Social Security Act or amendments thereto.

§ 51.1-301. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Appointing authority" means the General Assembly or the Governor.

"Creditable service" means prior service plus membership service, as further defined in and modified by § 51.1-303, for which credit is allowable under this chapter.

"Judge" means any justice or judge of a court of record of the Commonwealth, any member of the State Corporation Commission, *Medical Injury Compensation Board,* or Virginia Workers' Compensation Commission, any judge of a district court of the Commonwealth other than a substitute judge of such district court, and any executive secretary of the Supreme Court assuming such position between December 1, 1975, and January 31, 1976.

"Previous systems" means the systems established under the provisions of Chapters 2 (§ 51-3 et seq.) and 2.2 (§ 51-29.8 et seq.) of Title 51, and, in the case of judges of regional juvenile and domestic relations courts, the Virginia Retirement System.

"Primary social security benefit" means, with respect to any member, the primary insurance amount to which the member is entitled, for old age or disability, as the case may be, pursuant to the federal Social Security Act as in effect at his date of retirement, under the provisions of this chapter except as otherwise specifically provided.

"Retirement system" means the Judicial Retirement System.

"Service" means service as a judge.

§ 54.1-2523. Confidentiality of data; disclosure of information; discretionary authority of Director.

A. All data, records, and reports relating to the prescribing and dispensing of covered substances to recipients and any abstracts from such data, records, and reports that are in the possession of the Prescription Monitoring program pursuant to this chapter and any material relating to the operation or security of the program shall be confidential and shall be exempt from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 15 of § 2.2-3705.5. Further, the Director shall only have discretion to disclose any such information as provided in subsections B and C.

B. Upon receiving a request for information in accordance with the Department's regulations and in compliance with applicable federal law and regulations, the Director shall disclose the following:

1. Information relevant to a specific investigation of a specific recipient or of a specific dispenser or prescriber to an agent designated by the superintendent of the Department of State Police to conduct drug diversion investigations pursuant to § 54.1-3405.

2. Information relevant to an investigation or inspection of or allegation of misconduct by a specific person licensed, certified, or registered by or an applicant for licensure, certification, or registration by a health regulatory board; information relevant to a disciplinary proceeding before a health regulatory board or in any subsequent trial or appeal of an action or board order to designated employees of the Department of Health Professions; or to designated persons operating the Health Practitioners' Monitoring Program pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of this title.

3. Information relevant to the proceedings of any investigatory grand jury or special grand jury that has been properly impaneled in accordance with the provisions of Chapter 13 (§ 19.2-191 et seq.) of Title 19.2.

4. Information relevant to a specific investigation of a specific dispenser or specific prescriber to an agent of the United States Drug Enforcement Administration with authority to conduct drug diversion investigations.

C. In accordance with the Department's regulations and applicable federal law and regulations, the Director may, in his discretion, disclose:

1. Information in the possession of the program concerning a recipient who is over the age of 18 to that recipient.

2. Information on a specific recipient to a prescriber, as defined in this chapter, for the purpose of establishing the treatment history of the specific recipient when such recipient is either under care and treatment by the prescriber or the prescriber is initiating treatment of such recipient. In a manner

specified by the Director in regulation, notice shall be given to patients that information may be requested by the prescriber from the Prescription Monitoring Program.

3. Information on a specific recipient to a dispenser for the purpose of establishing a prescription history to assist the dispenser in determining the validity of a prescription in accordance with § 54.1-3303 when the recipient is seeking a covered substance from the dispenser or the facility in which the dispenser practices. In a manner specified by the Director in regulation, notice shall be given to patients that information may be requested by the dispenser from the Prescription Monitoring Program.

4. Information relevant to an investigation or regulatory proceeding of a specific dispenser or prescriber to other regulatory authorities concerned with granting, limiting or denying licenses, certificates or registrations to practice a health profession when such regulatory authority licenses such dispenser or prescriber or such dispenser or prescriber is seeking licensure by such other regulatory authority.

5. Information relevant to an investigation relating to a specific dispenser or prescriber who is a participating provider in the Virginia Medicaid program or information relevant to an investigation relating to a specific recipient who is currently eligible for and receiving or who has been eligible for and has received medical assistance services to the Medicaid Fraud Control Unit of the Office of the Attorney General or to designated employees of the Department of Medical Assistance Services, as appropriate.

6. Information relevant to determination of the cause of death of a specific recipient to the designated employees of the Office of the Chief Medical Examiner.

7. Information for the purpose of bona fide research or education to qualified personnel; however, data elements that would reasonably identify a specific recipient, prescriber, or dispenser shall be deleted or redacted from such information prior to disclosure. Further, release of the information shall only be made pursuant to a written agreement between such qualified personnel and the Director in order to ensure compliance with this subdivision.

D. The Director may enter into agreements for mutual exchange of information among prescription monitoring programs in other jurisdictions, which shall only use the information for purposes allowed by this chapter.

E. This section shall not be construed to supersede the provisions of § 54.1-3406 concerning the divulging of confidential records relating to investigative information.

F. Confidential information that has been received, maintained or developed by any board or disclosed by the board pursuant to subsection A shall not, under any circumstances, be available for discovery or court subpoena or introduced into evidence in any ~~medical malpractice suit~~ *claim pursuant to Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2* or other action for damages arising out of the provision of or failure to provide services. However, this subsection shall not be construed to inhibit any investigation or prosecution conducted pursuant to Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2.

§ 54.1-2900. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Acupuncturist" means ~~individuals~~ *an individual* approved by the Board to practice acupuncture. This is limited to "licensed acupuncturist" which means an individual other than a doctor of medicine, osteopathy, chiropractic or podiatry who has successfully completed the requirements for licensure established by the Board (approved titles are limited to: Licensed Acupuncturist, Lic.Ac., and L.Ac.).

"Auricular acupuncture" means the subcutaneous insertion of sterile, disposable acupuncture needles in predetermined, bilateral locations in the outer ear when used exclusively and specifically in the context of a chemical dependency treatment program.

"Board" means the Board of Medicine.

"Healing arts" means the arts and sciences dealing with the prevention, diagnosis, treatment and cure or alleviation of human physical or mental ailments, conditions, diseases, pain or infirmities.

"Medical ~~malpractice~~ *incident* judgment" means any final order of ~~any court~~ *the Medical Injury Compensation Board* entering ~~judgment~~ *an award* against a licensee of the Board that arises out of any ~~tort action or breach of contract action~~ *claim* for personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient, *pursuant to Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2*.

"Medical ~~malpractice~~ *incident* settlement" means any written agreement and release entered into by or on behalf of a licensee of the Board in response to a written claim for money damages that arises out of any personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Occupational therapy assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed occupational therapist to assist in the

practice of occupational therapy.

"Physician assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed doctor of medicine, osteopathy, or podiatry.

"Practice of acupuncture" means the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain ailments or conditions of the body and includes the techniques of electroacupuncture, cupping and moxibustion. The practice of acupuncture does not include the use of physical therapy, chiropractic, or osteopathic manipulative techniques; the use or prescribing of any drugs, medications, serums or vaccines; or the procedure of auricular acupuncture as exempted in § 54.1-2901 when used in the context of a chemical dependency treatment program for patients eligible for federal, state or local public funds by an employee of the program who is trained and approved by the National Acupuncture Detoxification Association or an equivalent certifying body.

"Practice of athletic training" means the prevention, recognition, evaluation, and treatment of injuries or conditions related to athletic or recreational activity that requires physical skill and utilizes strength, power, endurance, speed, flexibility, range of motion or agility or a substantially similar injury or condition resulting from occupational activity immediately upon the onset of such injury or condition; and subsequent treatment and rehabilitation of such injuries or conditions under the direction of a licensed physical therapist and the patient's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry, while using heat, light, sound, cold, electricity, exercise or mechanical or other devices.

"Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs, medicines, serums or vaccines.

"Practice of medicine or osteopathic medicine" means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method.

"Practice of occupational therapy" means the evaluation, analysis, assessment, and delivery of education and training in activities of daily living (ADL); the design, fabrication, and application of orthoses (splints); guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaptation of physical environments for individuals who have disabilities.

"Practice of podiatry" means the medical, mechanical and surgical treatment of the ailments of the human foot and ankle, but does not include amputation of the foot proximal to the transmetatarsal level through the metatarsal shafts. Amputations proximal to the metatarsal-phalangeal joints may only be performed in a hospital or ambulatory surgery facility accredited by an organization listed in § 54.1-2939. The Board of Medicine shall determine whether a specific type of treatment of the foot and ankle is within the scope of practice of podiatry.

"Practice of radiologic technology" means the application of x-rays to human beings for diagnostic or therapeutic purposes.

"Practice of respiratory care" means the (i) administration of pharmacological, diagnostic, and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a practitioner of medicine or osteopathic medicine; (ii) transcription and implementation of the written or verbal orders of a practitioner of medicine or osteopathic medicine pertaining to the practice of respiratory care; (iii) observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing, including determination of whether such signs, symptoms, reactions, behavior or general physical response exhibit abnormal characteristics; and (iv) implementation of respiratory care procedures, based on observed abnormalities, or appropriate reporting, referral, respiratory care protocols or changes in treatment pursuant to the written or verbal orders by a licensed practitioner of medicine or osteopathic medicine or the initiation of emergency procedures, pursuant to the Board's regulations or as otherwise authorized by law. The practice of respiratory care may be performed in any clinic, hospital, skilled nursing facility, private dwelling or other place deemed appropriate by the Board in accordance with the written or verbal order of a practitioner of medicine or osteopathic medicine, and shall be performed under qualified medical direction.

"Qualified medical direction" means, in the context of the practice of respiratory care, having readily accessible to the respiratory care practitioner a licensed practitioner of medicine or osteopathic medicine who has specialty training or experience in the management of acute and chronic respiratory disorders and who is responsible for the quality, safety, and appropriateness of the respiratory services provided by the respiratory care practitioner.

"Radiologic technologist" means an individual, other than a licensed doctor of medicine, osteopathy, podiatry, or chiropractic, or a dentist licensed pursuant to Chapter 27 (§ 54.1-2700 et seq.) of this title,

who (i) performs, may be called upon to perform, or who is licensed to perform a comprehensive scope of diagnostic radiologic procedures employing equipment which emits ionizing radiation and (ii) is delegated or exercises responsibility for the operation of radiation-generating equipment, the shielding of patient and staff from unnecessary radiation, the appropriate exposure of radiographs or other procedures which contribute to any significant extent to the site or dosage of ionizing radiation to which a patient is exposed.

"Radiologic technologist, limited" means an individual, other than a licensed radiologic technologist, dental hygienist or person who is otherwise authorized by the Board of Dentistry under Chapter 27 (§ 54.1-2700 et seq.) of this title and the regulations pursuant thereto, who performs diagnostic radiographic procedures employing equipment which emits ionizing radiation which is limited to specific areas of the human body.

"Radiologist assistant" means an individual who has met the requirements of the Board for licensure as an advanced-level radiologic technologist and who, under the direct supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology, is authorized to (i) assess and evaluate the physiological and psychological responsiveness of patients undergoing radiologic procedures; (ii) evaluate image quality, make initial observations, and communicate observations to the supervising radiologist; (iii) administer contrast media or other medications prescribed by the supervising radiologist; and (iv) perform, or assist the supervising radiologist to perform, any other procedure consistent with the guidelines adopted by the American College of Radiology, the American Society of Radiologic Technologists, and the American Registry of Radiologic Technologists.

"Respiratory care" means the practice of the allied health profession responsible for the direct and indirect services, including inhalation therapy and respiratory therapy, in the treatment, management, diagnostic testing, control and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system under qualified medical direction.

§ 54.1-2909. Further reporting requirements; civil penalty; disciplinary action.

A. The following matters shall be reported within 30 days of their occurrence to the Board:

1. Any disciplinary action taken against a person licensed under this chapter in another state or in a federal health institution or voluntary surrender of a license in another state while under investigation;

2. Any ~~malpractice~~ ~~judgment~~ *award entered pursuant to Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2* against a person licensed under this chapter;

3. Any settlement of a ~~malpractice~~ claim against a person licensed under this chapter *arising with respect to a covered injury, as defined in § 38.2-6400*; and

4. Any evidence that indicates a reasonable probability that a person licensed under this chapter is or may be professionally incompetent; has engaged in intentional or negligent conduct that causes or is likely to cause injury to a patient or patients; has engaged in unprofessional conduct; or may be mentally or physically unable to engage safely in the practice of his profession.

The reporting requirements set forth in this section shall be met if these matters are reported to the National Practitioner Data Bank under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq., and notice that such a report has been submitted is provided to the Board.

B. The following persons and entities are subject to the reporting requirements set forth in this section:

1. Any person licensed under this chapter who is the subject of a disciplinary action, settlement, judgment or evidence for which reporting is required pursuant to this section;

2. Any other person licensed under this chapter, except as provided in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;

3. The presidents of all professional societies in the Commonwealth, and their component societies whose members are regulated by the Board, except as provided for in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;

4. All health care institutions licensed by the Commonwealth;

5. The ~~malpractice~~ *medical incident* insurance carrier of any person who is the subject of a judgment or settlement; and

6. Any health maintenance organization licensed by the Commonwealth.

C. No person or entity shall be obligated to report any matter to the Board if the person or entity has actual notice that the matter has already been reported to the Board.

D. Any report required by this section shall be in writing directed to the Board, shall give the name and address of the person who is the subject of the report and shall describe the circumstances surrounding the facts required to be reported. Under no circumstances shall compliance with this section be construed to waive or limit the privilege provided in § 8.01-581.17.

E. Any person making a report required by this section, providing information pursuant to an

investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability or criminal prosecution resulting therefrom unless such person acted in bad faith or with malicious intent.

F. The clerk of any circuit court or any district court in the Commonwealth shall report to the Board the conviction of any person known by such clerk to be licensed under this chapter of any (i) misdemeanor involving a controlled substance, marijuana or substance abuse or involving an act of moral turpitude or (ii) felony.

G. Any person who fails to make a report to the Board as required by this section shall be subject to a civil penalty not to exceed $5,000. The Director shall report the assessment of such civil penalty to the Commissioner of the Department of Health or the Commissioner of Insurance at the State Corporation Commission. Any person assessed a civil penalty pursuant to this section shall not receive a license, registration or certification or renewal of such unless such penalty has been paid.

H. Disciplinary action against any person licensed, registered or certified under this chapter shall be based upon the underlying conduct of the person and not upon the report of a settlement or judgment submitted under this section.

§ 54.1-2910.1. Certain data required.

A. The Board of Medicine shall require all doctors of medicine, osteopathy and podiatry to report and shall make available the following information:

1. The names of the schools of medicine, osteopathy, or podiatry and the years of graduation;

2. Any graduate medical, osteopathic, or podiatric education at any institution approved by the Accreditation Council for Graduation Medical Education, the American Osteopathic Association or the Council on Podiatric Medical Education;

3. Any specialty board certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the American Board of Multiple Specialties in Podiatry, or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. The number of years in active, clinical practice as specified by regulations of the Board;

5. Any hospital affiliations;

6. Any appointments, within the most recent 10-year period, of the doctor to the faculty of a school of medicine, osteopathy or podiatry and any publications in peer-reviewed literature within the most recent five-year period and as specified by regulations of the Board;

7. The location and telephone number of any primary and secondary practice settings and the approximate percentage of the doctor's time spent practicing in each setting. For the sole purpose of expedited dissemination of information about a public health emergency, the doctor shall also provide to the Board any e-mail address or facsimile number; however, such e-mail address or facsimile number shall not be published on the profile database and shall not be released or made available for any other purpose;

8. The access to any translating service provided to the primary and secondary practice settings of the doctor;

9. The status of the doctor's participation in the Virginia Medicaid Program;

10. Any final disciplinary or other action required to be reported to the Board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment or a final order of the Board relating to disciplinary action;

11. Conviction of any felony; and

12. Other information related to the competency of doctors of medicine, osteopathy, and podiatry, as specified in the regulations of the Board.

B. In addition, the Board shall provide for voluntary reporting of insurance plans accepted and managed care plans in which the doctor participates.

C. The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request from a consumer, of such information relating to a specific doctor. The Board's regulations shall provide for reports to include all ~~medical malpractice judgments and medical malpractice~~ *awards by the Medical Injury Compensation Board and* settlements *arising with respect to a covered injury, as defined in § 38.2-6400,* of more than $10,000 within the most recent 10-year period in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances. Notwithstanding this subsection, a licensee shall report ~~a medical malpractice judgment~~ *awards by the Medical Injury Compensation Board* or ~~medical malpractice~~ settlement *arising with respect to a covered injury, as defined in § 38.2-6400,* of less than $10,000 if any other ~~medical malpractice judgment~~ *such award* or ~~medical malpractice~~ settlement has been paid by or for the licensee within the preceding 12 months.

D. This section shall not apply to any person licensed pursuant to §§ 54.1-2928.1, 54.1-2933.1, 54.1-2936, and 54.1-2937 or to any person holding an inactive license to practice medicine, osteopathy, or podiatry.

§ 54.1-2912.3. Competency assessments of certain practitioners.

The Board shall require an assessment of the competency of any person licensed under this chapter on whose behalf three ~~medical malpractice judgments~~ *awards by the Medical Injury Compensation Board* or ~~medical malpractice~~ settlements *arising with respect to a covered injury, as defined in § 38.2-6400,* of more than $10,000 are paid within the most recent 10-year period. The assessment shall be accomplished in 12 months or less by a program acceptable to the Board. The licensee shall bear all costs of the assessment. The results of the assessment shall be reviewed by the Board and the Board shall determine a plan of corrective action or appropriate resolution pursuant to the assessment. The assessment, related documents, and the processes shall be governed by the confidentiality provisions of § 54.1-2400.2 and shall not be admissible into evidence in any ~~medical malpractice action~~ *proceeding under Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2* involving the licensee. The Board shall report annually to the General Assembly the number of competency assessments undertaken.

§ 58.1-2501. Levy of license tax.

A. For the privilege of doing business in the Commonwealth, there is hereby levied on every insurance company defined in § 38.2-100 which issues policies or contracts for any kind of insurance classified and defined in §§ 38.2-102 through 38.2-134 and on every corporation which issues subscription contracts for any kind of plan classified and defined in §§ 38.2-4201 and 38.2-4501, an annual license tax as follows:

1. For any kind of insurance classified and defined in §§ 38.2-109 through 38.2-134 or Chapters 44 (§ 38.2-4400 et seq.) and 61 (§ 38.2-6100 et seq.) of Title 38.2, except workers' compensation insurance on which a premium tax is imposed under the provisions of § 65.2-1000 *and medical incident insurance on which a premium tax is imposed under the provisions of § 38.2-6460,* such company shall pay a tax of two and three-fourths percent of its subscriber fee income or direct gross premium income on such insurance for each taxable year through 1988. For taxable year 1989 and each taxable year thereafter, such company shall pay a tax of two and one-fourth percent of its subscriber fee income or direct gross premium income on such insurance.

2. For policies or contracts for life insurance as defined in § 38.2-102, such company shall pay a tax of two and one-fourth percent of its direct gross premium income on such insurance. However, with respect to premiums paid for additional benefits in the event of death, dismemberment or loss of sight by accident or accidental means, or to provide a special surrender value, special benefit or an annuity in the event of total and permanent disability, the rate of tax shall be two and three-fourths percent for each taxable year beginning January 1, 1987, through December 31, 1988, and two and one-fourth percent for taxable year beginning January 1, 1989, and each taxable year thereafter.

3. For policies or contracts providing industrial sick benefit insurance as defined in § 38.2-3544, such company shall pay a tax of one percent of its direct gross premium income on such insurance. No company, however, doing business on the legal reserve plan, shall be required to pay any licenses, fees or other taxes in excess of those required by this section on such part of its business as is industrial sick benefit insurance as defined in § 38.2-3544; but any such company doing business on the legal reserve plan shall pay on all industrial sick benefit policies or contracts on which the sick benefit portion has been cancelled as provided in § 38.2-3546, or which provide a greater death benefit than $250 or a greater weekly indemnity than $10, and on all other life, accident and sickness insurance, the same license or other taxes as are required by this section.

4. For subscription contracts for any kind of plan classified and defined in § 38.2-4201 or § 38.2-4501, such corporation shall pay a tax of two and one-fourth percent of its direct gross subscriber fee income derived from subscription contracts issued to primary small groups as defined in § 38.2-3431 and three-fourths of one percent of its direct gross subscriber fee income derived from other subscription contracts for taxable year 1997. For each taxable year thereafter, such corporation shall pay a tax of three-fourths of one percent of its direct gross subscriber fee income derived from subscription contracts issued to individuals and from open enrollment contracts as defined in § 38.2-4216.1, and two and one-fourth percent of its direct gross subscriber fee income derived from other subscription contracts. The declaration of estimated tax pursuant to this subsection shall commence on or before April 15, 1988.

B. Notwithstanding any other provisions of this section, any domestic insurance company doing business solely in the Commonwealth which is purely mutual, has no capital stock and is not designed to accumulate profits for the benefit of or pay dividends to its members, and any domestic insurance company doing business solely in the Commonwealth, with a capital stock not exceeding $25,000 and which pays losses with assessments against its policyholders or members, shall pay an annual license tax of one percent of its direct gross premium income.

§ 58.1-2502. Exemptions and exclusions.

Nothing in this chapter shall be construed to require any tax, other than taxes imposed upon property and the license tax imposed by § 38.2-4127:

1. Upon fraternal benefit societies as defined in § 38.2-4100.

2. Upon any mutual assessment fire insurance company as defined in §§ 38.2-2501 and 38.2-2503 which (i) confines its business to not more than four contiguous counties and cities located therein and wholly surrounded thereby in the Commonwealth, if any such city has a population of not more than 30,000, or (ii) confines its business to more than four contiguous counties in the Commonwealth if such counties together have a population not in excess of 100,000.

3. Upon premiums derived from workers' compensation insurance on which a premium tax is imposed under the provisions of § 65.2-1000.

4. Upon consideration for contracts for annuities as defined in § 38.2-106.

5. Upon premiums derived from medical incident insurance on which a premium tax is imposed under the provisions of § 38.2-6460.

2. That §§ 8.01-20.1 and 8.01-50.1, Article 1 (§§ 8.01-581.1 through 8.01-581.12:2) of Chapter 21.1 of Title 8.01, and §§ 8.01-581.13, 8.01-581.15, 8.01-581.20, 16.1-83.1, and 38.2-5020.1 of the Code of Virginia are repealed.

3. That the provisions of this act shall become effective on July 1, 2012, and shall not apply to any cause of action arising with regard to personal injury or death resulting from the delivery of health care services by a health care provider prior to July 1, 2012.