



VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM

PROGRAM GUIDELINES (APPROVED APRIL 13, 2004)

Important Note: The following guidelines only summarize current benefits provided to admitted claimants in the Program and are not a guarantee of benefits. Purchases and expenditures for admitted claimants must be pre-approved by the Program. Guidelines are subject to change by the Board of Directors of the Virginia Birth-Related Neurological Injury Compensation Program and by the Virginia General Assembly.

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The Virginia Birth-Related Neurological Injury Compensation Program is one example of a public-private partnership that works. It provides a wide range of benefits to a child who satisfies the Virginia statutory definition of “birth-related neurological injury” and is delivered by a physician or midwife, or in a hospital, that participates in the Program.

Purpose Of The Program

The Birth-Injury Program was created by the General Assembly for two primary reasons: (1) to provide benefits to admitted claimants over their lifetime without having to resort to the tort law system for recovery and (2) to assure that the medical community will continue to provide obstetric services in Virginia.

Nature Of The Program

Because the Birth-Injury Program is not concerned with fault, it does not operate in the same way as a typical court proceeding. When a child is admitted to the Program there is not a discrete amount of money set aside for the claimant’s needs. Rather, the Program operates much like a health insurance company and pays each admitted claimant’s qualifying and medically necessary costs as they occur. The actual amount the Program spends per admitted claimant varies greatly depending on the needs of each child, other sources of payment, and other factors.

With exceptions, the benefits of the Birth-Injury Program are limited to actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential/custodial care and service, special equipment, facilities and related travel. By law, the Birth-Injury Program is a payer of last resort – that is, it pays after available insurance, governmental programs, or other responsible sources have paid. A unique feature of the Program provides for payments of "loss of earnings" to the admitted claimant when he/she reaches the age of eighteen years based upon a formula described in the Virginia statute.

Financing Of The Program

The Birth-Injury Program is financed by assessments and fees, in varying amounts, collected from hospitals with obstetric units, licensed physicians who practice obstetrics or perform services, including licensed nurse-midwives, all other licensed physicians and liability insurance carriers licensed and engaged in writing coverage in Virginia.

Governance And Operation

A seven member Board of Directors governs the Program and employs an Executive Director. The Governor of Virginia appoints all Board members. The directors are assisted by a number of other professionals to provide admitted claimants with the required services. The Board meets monthly and all meetings are open to the public.

Claims for compensation from the Program are made to, and awarded by, the

Virginia Workers' Compensation Commission. Once a claim is awarded, the Program will communicate and visit with the parents or caregivers of the child to determine his/her needs.

Program Is Payer Of Last Resort

As discussed earlier, the Birth-Injury Program is the "payer of last resort." Each admitted claimant's primary insurance and other sources of coverage should be billed for covered services before the Program is asked to pay for a service. An admitted claimant that is eligible for public health insurance or other services that the Program covers must make a good faith effort to enroll and receive benefits from these sources (for example, Medicaid or FAMIS).

Primary Insurance

Medical services that are required to be pre-certified, pre-authorized, or authorized by the admitted claimant's primary insurance provider may not be payable by the Program if the primary insurance carrier's certification or authorization process has not been satisfied.

Claimants must utilize the primary insurer's in-network providers and facilities unless otherwise authorized by the Program. Utilizing non-network or non-participating providers or facilities may result in reduced payment or non-payment of incurred expenses.

Medical Review

The Program reserves the right to submit requests for services or equipment for independent medical review to determine medical necessity or appropriateness of care prior to authorizing payment.

BENEFITS

Counseling

The Program will pay for counseling for family members related to the needs of an admitted claimant. After primary insurance, a maximum of \$1,500 per calendar year will be paid for this service. Services must be provided by a licensed clinical social worker, counselor, psychologist or psychiatrist.

Personal Nursing And Assistive Care

A. The Program will pay for appropriate medically necessary and reasonable nursing care or assistive care as recommended in writing by the admitted claimant's primary care physician. The Program will not pay for a caregiver that is a relative, member of the household or significant other of the claimant or a member of the admitted claimant's immediate family (parent, guardian, brother, sister, aunt, uncle, grandparent).

B. The Program will review/consult periodically with medical professionals concerning the continued appropriateness of the nursing hours.

C. The Program utilizes nursing agencies when available. If an agency is unable to provide care, the Executive Director is authorized to approve other arrangements.

D. If a nursing agency is not available, the Program may reimburse the admitted claimant's family or guardian for care providers who are employed by the claimant's family as independent contractors upon approval of the Executive Director. The Program will reimburse admitted claimant families for employment-related taxes such as FICA or unemployment tax upon receipt of proper documentation of payment of these taxes. (Note: The Program, however, discourages employment of personnel not associated with a nursing agency because of cost and quality of care issues that experience has demonstrated can occur.)

E. The Program will not reimburse a care provider for more than a 16-hour shift within a 24-hour period unless there is an emergency and no other care provider is available to care for the child. Overtime is not paid unless pre-authorized by the Program. The Program will not reimburse for work by a fulltime caregiver for more than 40 hours per week unless preauthorized by the Program.

F. The Program will not provide a private duty nurse while an admitted claimant is hospitalized unless the attending physician considers it medically necessary and a written order for private duty nursing is provided to the Program. The Program will pay for a sitter who is not a family member and may not have

medical experience, while the child is hospitalized, if requested, and with prior approval from the Program and a letter of medical necessity from the attending physician.

G. The Program will provide nurses to accompany admitted claimants during school hours provided such care is deemed medically necessary and is not otherwise available. This care counts toward the total approved nursing hours.

H. The Program will reimburse medically necessary care provider expenses if they have not been previously filed with the tax authorities as deductions/credits. If they have been filed with the tax authorities as deductions/credits, then an amended tax report must be filed with the tax authorities and a copy of the amended tax report provided to the Program before the family will be reimbursed for these expenses.

I. The Program does not provide payment to parents or guardians of admitted claimants for their care of the claimant.

J. The Program generally follows Medicaid payment rates depending on the locality or state where the care is delivered.

K. Travel expenses associated with nursing care are reimbursable only if the travel is medically necessary. No travel expenses will be paid for nurses or

caregivers accompanying families on vacation or other non-medically necessary travel.

Dental Care

The Program will pay for the child's dental care costs if they are not covered by other sources.

(Important Note - April 13, 2004: The Board of Directors voted to retain the above Dental Care policy pending a requested recommendation for policy from medical and dental specialists.)

Therapy

A. The Program will pay for therapy that is determined to be medically necessary and reasonable, and for which there is a certificate of medical necessity provided by the admitted claimant's primary care physician.

B. The Program may consult periodically with appropriate medical professionals regarding the necessity for continuing various therapies including, but not limited to, behavioral, physical, horseback and speech therapy.

C. Experimental Therapy: Experimental therapy, music therapy and other therapies typically not covered by health insurance companies will be covered up to a maximum of \$1,000 per year with prior authorization from the Executive Director of the Program. A letter of medical necessity from the admitted claimant's primary care physician is required.

Transportation - Vans

A. The Program will fund the purchase of a van when it becomes medically necessary for wheelchair transportation. Van options for admitted claimant families are available from the Program. The Birth-Injury Program will have the primary lien on the van's certificate of title, although the van itself will be titled in the name of the parents or guardians. The Program will pay the personal property taxes on the medically necessary van and also will pay an amount equal to the Uninsured Motorist Fee, or the insurance premium for the van, whichever is less. Other operating costs, such as city/county decals and tags, maintenance, repairs and tires will be the responsibility of the parents or guardians. Mileage and other transportation costs will be reimbursed as set out elsewhere in this policy (see miscellaneous costs). The Program will reimburse the admitted claimant's family for the cost of insuring the lift and tie downs if an additional cost is incurred for this and a receipt is provided.

B. Van Replacement: Vans will be replaced at approximately 100,000 miles. Documentation of the vehicle's service history and condition will be considered in determining the timing of van replacement.

C. Return of Vans: In the event a van provided by the Program is no longer necessary for transportation of the child, the van must be returned and title transferred to the Program within three months. The family may purchase the van if an agreeable purchase price is agreed upon with the Executive Director of

the Program.

D. All vans returned to the Program should be in good working order and be able to pass a Virginia state inspection.

Equipment

A. Equipment documented as medically necessary by the claimant's physician will be provided by the Program. Because there is a gamut of equipment that may be provided, no attempt is made to list all such equipment in these Guidelines. Equipment provided to date, however, includes oxygen concentrators, bipap machines, feeding pumps, gait trainers, wheelchairs, Wizard strollers, suction machines, apnea monitors, IV poles, pulse oximeters, therapy balls, therapy mats, Gorilla car seats, wheelchair lifts, and wheelchair tie-downs.

B. All medically necessary equipment (except vans) purchased entirely by the Program remains the property of the Program. Depending upon the type of equipment and its condition, it is expected that equipment will be returned to the Program when no longer required by the child. The family may purchase the equipment if a purchase price is agreed upon with the Executive Director. If the equipment is not purchased entirely by the Program it does not have to be returned to the Program

Augmentative Communication Technology

A. The Program will pay for devices, equipment and computer software for the purpose of aiding in communication of an admitted claimant who otherwise is unable to communicate verbally. The Program may require an evaluation be completed by a Program assigned augmentative communication consultant to ensure the appropriate equipment is recommended and/or purchased.

For all equipment supplied by the Program, it is expected that the admitted claimant and those involved in the care of the claimant will utilize the equipment as intended and invest the time and effort required for the equipment to be utilized successfully.

B. In accordance with the Program's general policy on purchasing medically necessary equipment, all augmentative communication technology equipment remains the property of the Program. If for any reason the equipment no longer is necessary or not utilized by the admitted claimant, it should be returned to the Program. The Program is the "payer of last resort." (Therefore, all measures for obtaining coverage through primary insurance or other sources must be exhausted before the Program will cover augmentative technology services.)

Privately Owned Housing Assistance:

The Board's statutory authority concerns awards for the medical needs of the admitted claimants it serves. However, if an admitted claimant has medically necessary housing needs that can be addressed in the non-rental home currently

owned and occupied by the admitted claimant's family or guardian, the Board will provide one-time funding for medically necessary modification to, or construction of, an accessible bedroom and bathroom if such modification or construction is feasible and reasonable. This modification or construction must be within the Program's allowable standards for cost, space and other factors before funding for an accessible bedroom and bathroom will be authorized. The Program's construction manager or other qualified professional will determine the feasibility of these modifications or construction and whether the admitted claimant's needs will be met in the contemplated project.

Rental Housing Assistance

A. If the claimant resides in a non-handicapped accessible rental unit and moves to a handicapped accessible rental unit, the Program will reimburse the difference between the former monthly rental payment and the cost for the appropriate handicapped accessible rental unit of similar size and quality based on cost per square foot. Any substantial increases in the square footage of the handicapped accessible unit to be reimbursed must be attributable to medically necessary requirements and not exceed the overall guidelines utilized when the Program constructs additional space for a claimant.

B. The handicapped accessible rental unit should meet all applicable regulations of the Americans With Disabilities Act. Exceptions to meeting the ADA regulations must be approved by the Program's Board of Directors. Prior to providing reimbursement the Program may require certification of the rental unit's

suitability for the claimant and/or compliance with this policy.

C. The maximum lifetime housing benefit per claimant for any one or combination of housing benefits (rental and/or construction) is \$175,000.

Funeral Expenses

The Program will pay a maximum of \$5,000 for the funeral and burial expenses of an admitted claimant.

Attorneys' Fees

Virginia law authorizes (but does not require) payment of reasonable attorneys' fees incurred in the initial filing of a claim to enter the Program, subject to the approval and award of the Commission.

Miscellaneous Expenses

A. **Transportation:** Upon submission of receipts, the Program will reimburse parking fees associated with medically necessary travel. The Program will reimburse documented mileage for medically necessary travel at the following rates:

1. Mileage will be reimbursed at fifty (50%) percent of the Commonwealth of Virginia's mileage rate for vans provided by the Program. Mileage reimbursement typically covers gasoline and other costs of operation. Since the Program provides the van in this instance, the Program's mileage reimbursement is

intended only to cover the cost of gasoline associated with medically necessary transportation. Mileage is based on the distance from the home to the appointment location. Verification may be required by the Program.

2. For use of personal vehicles, reimbursement will be at the prevailing rate paid by the Commonwealth of Virginia to its employees. In the event a van provided by the Program is unavailable, the mileage reimbursement allowance provided would be that allowed for vans purchased by the Program. Upon submission of receipts, the Program will reimburse other medically necessary transportation expenses not otherwise reimbursed.

B. Postage: The Program will pay postage for reimbursement requests submitted to the Program and for information requested by the Program.

C. Cell Phones: If the Program receives a prescription from the admitted claimant's physician that a cellular telephone is medically necessary, the Program will pay for basic monthly emergency service. If basic *emergency service* is unavailable, the Program will pay for basic monthly service only. If installation of the cellular telephone is required, the phone must be installed in the vehicle in which the admitted claimant is transported (Please contact the Program for the current allowable amounts).

D. Diapers: Beginning at age three, the Program will pay for diapers for an admitted claimant when deemed medically necessary and under the usual

reimbursement and purchasing guidelines.

E. Therapeutic Toys: The Program will provide therapeutic toys with documentation of the therapeutic benefit of the toy(s). These toys are not to exceed \$300 per calendar year. Once the child has no need for these toys and if they are in good condition, the Program would be happy to accept their return to be used to stock a lending program. The toys will be sanitized prior to use by other families.

F. Other: The Program may pay other medically necessary expenses of the admitted claimant as determined by the Board of Directors in its discretion. Requests for medically necessary services, etc. that are not addressed in the Guidelines should be sent to the Executive Director who will refer these requests to the Board of Directors for action.

Other Procedures

A. Insurance: Because the Program is the payer of last resort, it must be provided with a copy of the applicable health insurance policy, if one exists, or a complete description of applicable coverage, before benefits are paid by the Program. It is the responsibility of the parents or guardians to seek benefits for which an admitted claimant is eligible. In addition, the parents or guardians of the admitted claimant must identify a primary care physician.

Claimants must utilize the primary insurer's in-network providers and facilities

unless otherwise authorized by the Program. Utilizing non-network or non-participating providers or facilities may result in reduced payment or non-payment of incurred expenses.

B. Reimbursement: Although a claimant has been determined eligible for benefits from the Program, parents or caregivers must contact the Program before committing to the purchase of equipment or incurring other expenses for which they may seek reimbursement. Failure to do so may jeopardize reimbursement from the Program. In the case of emergency care rendered or sought during non-business hours, the claimant family is responsible for contacting the Program the next business day for authorization of services the Program is expected to pay for.

C. Claims For Reimbursement: Requests for reimbursement of expenses from medical providers, pharmacies, equipment providers, medically necessary mileage, or other expenses will not be honored if submitted after one year from the date they are incurred. All reimbursement requests must be accompanied by documentation of medical necessity and receipts from providers. This time limit does not apply to expenses incurred prior to acceptance into the Program. All requests for reimbursement for expenses prior to entry into the Program must be submitted within two years of entry into the Program.

D. Requests For Authorization To Obtain Services Outside Your Insurance Plan's Covered Area Or Network: In the event it is medically necessary to take

an admitted claimant outside the claimant's applicable insurance plan's covered service area or the primary insurance's provider network for evaluation, surgery, etc., it must be ascertained if the primary insurance plan will pay for benefits and if so, what amount it will pay. After this is determined, the Program must be contacted for authorization prior to seeking services or the Program may determine not to pay any balance remaining on the bill for these services.

If an in-network provider is available for a service and an out-of-network provider is utilized, the Program only will reimburse or pay in an amount equal to what the Program would have paid if an in-network provider had been utilized.

E. Medically Necessary Travel More Than 100 Miles From Claimant's Primary Residence: In the event it is medically necessary to take an admitted claimant outside the local service area (more than 100 miles from the claimant's primary residence) for evaluation, surgery or other medically necessary care, it must be ascertained prior to the travel if the travel related expenses will be reimbursed by the Program. If pre-authorization is not obtained, the Program may not pay for these travel related expenses.

F. Requests For Benefits Not Specifically Addressed In Guidelines: These Guidelines authorize the Executive Director to provide the benefits described without referral to the Board except in exceptional circumstances, and in the Executive Director's discretion. The Board, however, realizes that there may be programs, equipment, or other items, which may be of value to an admitted

claimant that these Guidelines do not address. If the parents or guardians feel a benefit not described in the Guidelines would be of value to the admitted claimant (the Executive Director is not authorized to provide those benefits without Board approval), the parents or guardians should write the Board via the Executive Director, who will bring these requests to the Board at their next meeting.

Experimental Programs: When a request is made to fund participation in an Experimental Program, the Board will evaluate the request based on the following criteria:

1. Overall cost associated with the Experimental Program. Cost for one person to accompany the admitted claimant (if necessary); duration of the Program; expected benefits to the claimant; and availability of the program in Virginia, if located outside of the area of residency.
2. Report from the admitted claimant's primary care physician of the medical necessity for the admitted claimant to participate in the Experimental Program.
3. Proof of results that the Experimental Program has benefited other patients in similar circumstances.
4. The expected frequency and duration of the Experimental Program requested.
5. Continuation of the program will be permitted if periodic evaluation by a

physician shows the program to be of benefit to the admitted claimant.

The Board in its discretion may consider other criteria.

G. Disagreements: Disagreements concerning whether a service or item of equipment should be paid by the Program may arise. If the Executive Director cannot resolve a disagreement, then the Executive Director has been charged by the Board to advise it of such disputes at its regular meetings. The parents or guardians may submit a written explanation of the dispute and request resolution by the Board and/or attend a meeting. If a dispute is not resolved by the Board of Directors, a petition of appeal may be filed with the Clerk of the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, Virginia 23220.