A lifetime of help

Participant Handbook

AUGUST 2018

VIRGINIA BIRTH-RELATED
NEUROLOGICAL INJURY
COMPENSATION PROGRAM

This handbook provides practical assistance in understanding the benefits available through this program. It is not intended to be a complete nor legally binding guarantee of benefits. The procedures, and procedures it contains are subject to change by the Board of Directors of the Virginia Birth-Related Neurological Injury Compensation Program and by the Virginia General Assembly.

Table of Contents

About the Program

Its Purpose

The Virginia General Assembly created the Birth-Related Injury Program in 1987 to meet two basic needs:

1. To provide benefits for children suffering from birth-related neurological injuries over their lifetimes. Their families would not be forced to file lawsuits against physicians, hospitals, or insurance companies as a way to pay for their children's care.

2. To support the efforts of Virginia hospitals and physicians providing obstetric services so that residents of Virginia would be able to continue receiving these services.

Program benefits are typically limited to reimbursement for medically necessary and reasonable expenses of:

- Medical and hospital care
- Rehabilitation
- Residential/custodial care and services
- Special equipment
- Related travel

The Program is a "Payer of Last Resort"

To be a payer of last resort means that the Program is intended only to be a safety net that pays any expenses remaining after all available insurances and any other sources have paid the expenses they cover.

The Program vs. Medical Malpractice Lawsuits

How a Lawsuit Works

You must hire an attorney to file a medical malpractice liability lawsuit on your behalf. You may also need to find medical experts who will testify in court about the reasons for your child's injury.

In a lawsuit, the court must decide who is at fault to determine whether or not the plaintiff (you and your child) should receive compensation from the defendant (the doctor, hospital, insurer, or whomever you have named in the lawsuit).

If you win a lawsuit, the court decides how much money you will be paid. This amount may not be enough to cover all the expenses you will have over the course of your child's lifetime.

How the Program Works

The Virginia Birth-Related Neurological Injury Compensation Act does not create a fault-based Program. This "no fault" approach simply means that the one applying for entry into the Program need not prove that a healthcare provider breached a duty or standard of care in order to be eligible for benefits.

In the Program, a certain amount of money is not set aside for each person who participates. The Program works more like a health insurance company. It pays reasonable and medically necessary expenses after you have exhausted all other methods of reimbursement. The amount the Program spends on each participant can vary greatly over the participant's lifetime, depending on the person's needs, other sources of compensation, and other factors.

Only One Method of Payment Allowed

You cannot be covered under the Program AND recover from a medical malpractice lawsuit. Eligibility for the Program means that you no longer have the option to sue anyone over your child's injury.

Key Points for Eligibility for the Program

To be eligible for the Birth-Injury Program

Your child must have been delivered by a physician or hospital that participates in, or signed an agreement and paid a fee to, the Program. You should have been given this information by one or both before your child was born.

In addition to being delivered by a physician or in a hospital that participates in the Program, your child must meet some or all of the following conditions:

- Suffered a neurological injury related to his or her birth, as defined by Virginia law.
- The injury must have resulted from oxygen deprivation or mechanical injury during labor, delivery, or resuscitation.
- Is permanently motorically disabled and developmentally disabled **OR**

  Cognitively disabled, if the child is old enough to have his or her cognitive skills evaluated.
- Will always need help with all the activities of daily living.
- Must be less than 10 years old when an initial petition for entry into the Program is submitted to the Workers' Compensation Commission (WCC).

The Program's Structure

Where the Money Comes From

The Program operates on money contributed from a variety of sources.

The contributors are hospitals with obstetric units, licensed physicians and midwives who practice obstetrics, and liability insurance companies who do business in Virginia. They pay regular assessments and fees.

Others also pay to keep the Program running. Additional funding comes from all other licensed Virginia physicians. The Program receives no direct funding from the Commonwealth of Virginia.

To find the most up-to-date list of physicians and hospitals who are Program participants, contact the Program.

Who Manages the Program

The Program is managed by a nine-member Board of Directors and an Executive Director. All Board members are appointed on a volunteer basis by the Governor of Virginia. They are not paid for their services.

The Executive Director is chosen by the Board of Directors. This person handles day-to-day management of the Program, assisted by a small staff. (See *How to Contact Us* for the staff's specific duties.)

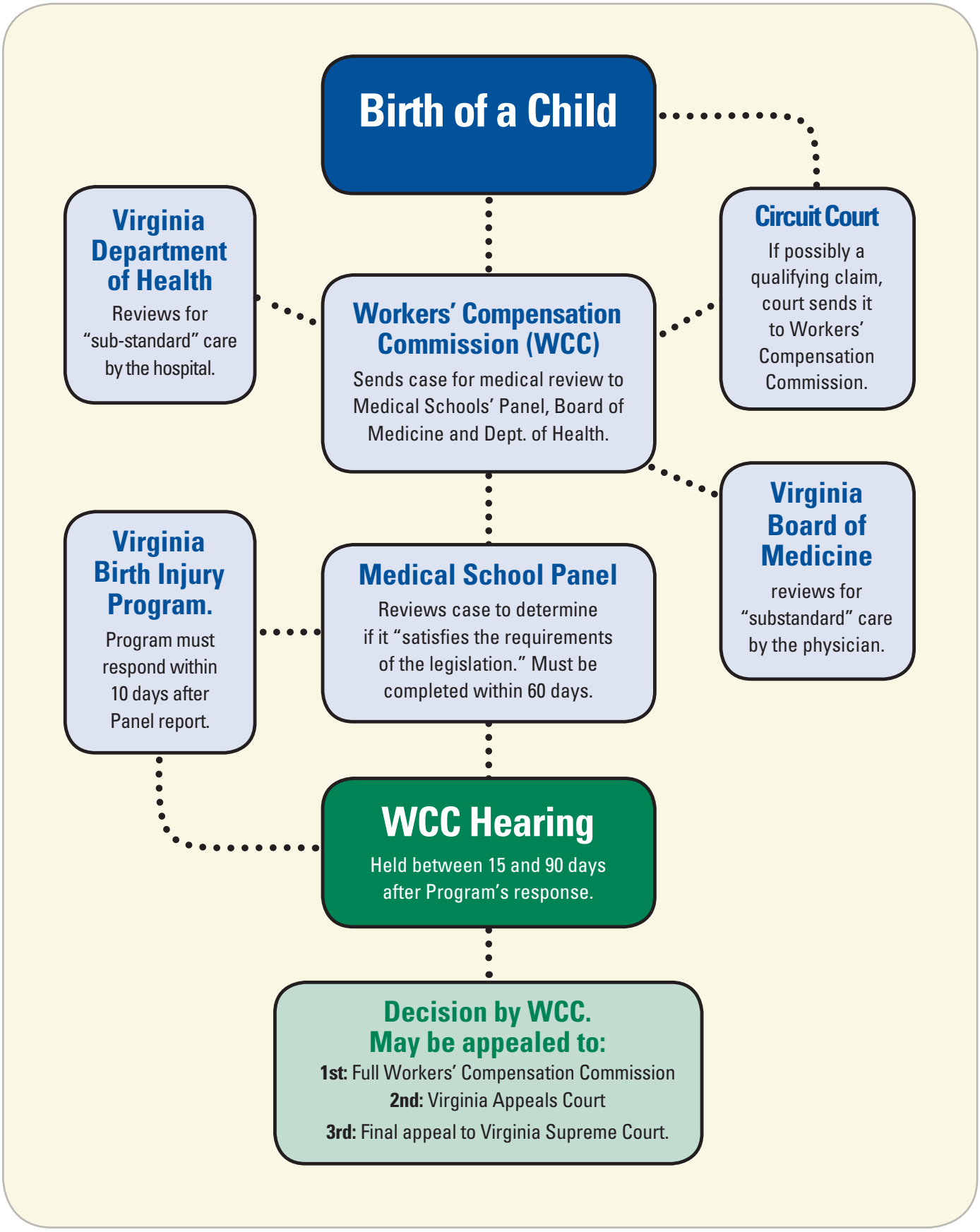
Claims to participate in the Program are submitted to The Virginia Workers' Compensation Commission. This Commission makes the decision on whether or not a child is eligible for entry into the Program.

Board Meetings are Open to You

The Board of Directors holds monthly meetings that are open to the public. Meetings are usually held at the Program's office at 7501 Boulders View Drive, Boulders IV, Suite 210, Richmond, VA 23225.

If you want to attend a meeting, we highly recommend that you check the Program's Web site at www.vabirthinjury.com to see if there has been a schedule change. Or call our Administrative Assistant at 804-330-2471, extension 3010.

How the Application Process Works



Other Groups Who Assist the Program

As you work with the Program, you may deal with other entities that are associated with the Program. They are:

- Virginia Attorney General's office: Represents the Commonwealth/Program.
- State Corporation Commission: Reviews the Program's Plan of Operation and decides the amount of assessments to be paid by contributors to the program.
- Secretary of the Commonwealth, Governor's office: Appoints members to the Program's Board of Directors.
- VCU Medical College of Virginia: Provides medical review panels.
- University of Virginia Medical School: Provides medical review panels.
- Eastern Virginia Medical School: Provides medical review panels.

Frequently Asked Questions

Q. Does every state have a Birth-Injury Program?

A. No. A similar program has been established in Florida, and some other states have other methods and programs to deal with similar issues. The Virginia Birth-Injury Program does regularly receive inquiries from other states, and even other countries, concerning the establishment of a program.

Q. How does the Birth-Injury Program benefit all Virginians?

A. The Birth-Injury Program, in conjunction with other state efforts, helps hold down the cost of medical malpractice insurance for all physicians in Virginia, and helps to keep obstetrical and other medical services available to all Virginians.

Q. What qualifies a child to enter the Birth-Injury Program?

A. A child must be delivered either in a hospital by a participating provider (physician/midwife) or at a participating hospital. The child's injuries also must meet the definition of a qualifying birth-injury as outlined in state law.

Q. What is the legal definition used to define a qualifying birth-injury?

A. Section 38.2-5001, Code of Virginia states:

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery, in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled. In order to constitute a

"birth-related neurological injury" within the meaning of this chapter, such disability shall cause the infant to be permanently in need of assistance in all activities of daily living. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse. The definition provided here shall apply retroactively to any child born on and after January 1, 1988, who suffers from an injury to the brain or spinal cord caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post delivery period in a hospital."

Q. Does the Program cover children with birth defects?

A. The law does not apply to disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or substance abuse by the infant's mother.

Q. How do I know if my obstetrician or hospital participates in the Program?

A. All providers are required by law to inform obstetrical patients whether or not they participate in the Birth-Injury Program. You also can contact the Program for information. Information on participants in prior years is available from the Program.

Q. If my physician or hospital participates in the Birth-Injury Program and a qualifying birth-injury occurs, what happens?

A. The chances of a birth-injury are very small, however, if it does occur you may petition for your child to enter the Birth-Injury Program. The law provides that awards under the Program are exclusive. That means that if an injury is covered by the Program, the child and his or her family are not entitled to compensation from a malpractice lawsuit.

Q. Is a lawyer needed to file a petition to enter the Birth-Injury Program?

A. A lawyer is not required, however most claimants do have legal counsel. If a lawyer is used, the Workers' Compensation Commission may award reasonable legal fees if the child is admitted into the Program.

Q. How long after a birth may a petition be filed?

A. There is a ten-year statute of limitations on filing initial claims.

Q. Who decides if a child qualifies for the Birth-Injury Program?

A. All petitions for entry into the Birth-Injury Program must be filed with the Virginia Workers' Compensation Commission (WCC). The WCC has sole authority to enter a claimant into the Program.

Q. My child is newly admitted to the Birth-Injury Program. How do I learn more about the Program?

A. You will be contacted by the Program to conduct an orientation session. You may also contact the Program with any questions.

Q. How much compensation is a participant entitled to?

A. Entry into the Birth-Injury Program does not provide for any set amount of compensation. The Program operates much like an insurance policy in that it pays for actual, reasonable and medically necessary costs and other legislatively stipulated benefits. Additionally, the Program is generally the payer of last resort. There is no cap on the total eligible lifetime costs.

Q. How is the Birth-Injury Program funded?

A. The Birth-Injury Program does not receive state funds. Funding is provided through four sources: Fees paid by participating physicians and hospitals; assessments of liability insurance carriers operating in Virginia; and assessments of non-participating physicians practicing in Virginia.

Q. I am interested in serving on the Board of Directors of the Birth-Injury Program. How do I volunteer?

A. All nine board members are appointed by the Governor of Virginia. Three of the nine positions are representatives of specific industries. The remaining are citizen representatives who must meet certain requirements. For information on appointments, contact the Secretary of the Commonwealth's office.

Q. How do I keep abreast with what's going on with the Birth-Injury Program?

A. As needed, the Program communicates with all participants, usually by letter. We also post a lot of information on our Web site at **www.vabirthinjury.com.** All Virginia Birth-Injury Program board meetings are open to the public (however, discussions of specific participant issues are held in closed sessions pursuant to confidentiality requirements of the Act). If you plan to attend a board meeting and speak with the board, while not required, we encourage you to let the Executive Director know in advance so you may be placed on the agenda and provided sufficient time to speak.

Q. I understand that the Program has a set of Regulations. How do I get a copy?

A. You may get a copy of the Regulations on our Web site at **www.vabirthinjury.com** or call us and we will send them to you.

Q. How will I know if the Program changes its Regulations?

A. The Regulations do not change often; however, we generally notify all participants if they do. In addition, notice of proposed changes are printed in the Virginia Register during a comment period. They also may be posted on our Web site at **www.vabirthinjury.com.**

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

About Expenses

Which Expenses and Services are Covered

A participant in the Program can be covered for these expenses and services after you have pursued all other reimbursement options with government programs and insurance plans. All covered expenses and services must be medically necessary.

- Medical
- Hospital
- Rehabilitation/therapy
- Residential/custodial care
- Special equipment
- Reasonable claim filing costs (including reasonable attorney's fees related to the filing of the claim)
- Medically necessary travel
- Compensation for lost earnings from age 18 to 65

Note: Reimbursement rates for some services, primarily where costs fluctuate regularly, are reviewed every three years or more often as needed.

Please note that pre-authorization must be obtained from the Program prior to the purchase of equipment or services.

Program Participation Card

When you are accepted into the Program, you receive a card similar to the one most health care insurance companies provide as proof of coverage. This may be provided through a contracted Third Party Administrator (TPA). Ask your physicians and other health care providers to make a copy of your Program card so they will have the information they need to bill the Program directly for any outstanding balances after all allowable charges have been paid by your other sources. This will help to limit your out-of-pocket expenses.

Working with Your Existing Health Insurance and Other Programs

Submitting Claims

You need to file claims directly with your primary insurance provider before submitting claims for expenses to the Program.

Getting Pre-Authorizations

If your primary insurance provider requires pre-certification or pre-authorization for medical services, you must follow that procedure. If the primary insurer refuses to pay a claim because the proper procedure was not followed, the Program may also be unable to pay that expense.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Staying in the Network

If the primary insurer has a network of healthcare providers and facilities, you are required to use them. In extraordinary circumstances, if you must obtain care from a provider not in the network, you must get authorization in advance from the Program. However, before the Program will consider such requests, you must have exhausted all available appeals processes offered by your primary insurer. If you go outside the insurer's network without approval, it can mean reduced payments from the insurer and the Program, or no payment at all.

If you use an out-of-network provider when an in-network provider was available, the Program will only reimburse the amount it would have paid for an in-network provider.

Who Pays Insurance Co-Payments

All providers in your insurance company's network have a contract with the insurance company for co-payment amounts (co-pays) and must charge you accordingly.

If you are charged additional fees or co-pays not specifically allowed under your policy, you do not have to pay them. The Program is also unable to pay them.

The Program will reimburse you for approved insurance co-pays after you pay them out-of-pocket, or arrangements usually can be made for the Program to pay them directly to the provider.

Working with the Program

Information You Must Provide

The Program needs certain information from you so we can process requests for payments correctly. When you participate in the Program, we ask for:

- A copy of the participant's health insurance policies.

Each benefit also has certain forms you must complete or receipts you must provide. They are described in this Handbook.

Submitting Claims

Once your child is accepted into the Program, we contact you to determine the participant's needs so we know what expenses to expect.

To facilitate prompt and accurate processing it is recommended that claims be submitted within one year of the date they were incurred. We recommend that you submit all expenses at least once a month using the Claim Reimbursement Form. A copy of the form to duplicate and use is on the Program's website.

A checklist of what you need for submitting claims is at the end of this section.

Pre-authorization is generally required for purchase of services or equipment especially if the purchase is not covered by the primary insurer.

Handling Emergency Situations

The Program recognizes that emergencies happen during non-business hours or weekends. You may be unable to get pre-authorization from your insurance company or the Program.

We expect you to contact the Program no later than the next business day, or as soon as is reasonably possible, to explain the emergency and to get authorization for any expenses the Program will be asked to pay.

Requesting Exceptions to the Benefits

If you feel the participant would be helped by benefits not specifically outlined in the Program's Regulations, you may request an exception. The Board of Directors must approve all exceptions. The Executive Director is not able to authorize exceptions without Board approval.

This is how it works:

1. You write a letter to the Executive Director describing the benefit and explaining why you feel it is necessary for the participant. You must also submit all supporting documentation including, but not limited to, any letter(s) of medical necessity.

2. The Executive Director presents your request to the Board of Directors at its next regular meeting. You are welcome to attend the meeting to present your request.

You receive a letter stating the Board's decision.

Requesting Experimental Treatment or Therapy

Healthcare is an ever-changing field, and you may find a new therapy not specifically mentioned in the Regulations. You must write a letter to the Executive Director to request an experimental therapy. The Board of Directors will evaluate your request based on these conditions:

- Overall cost for one person to accompany the participant, the length of time the therapy will take, the expected benefits to the participant, the therapy's availability in Virginia if the therapy *is not available locally for the participant.*
- A report from the participant's physician on the medical necessity for receiving the therapy.
- Proof of results from professionally recognized and credible medical sources that the experimental therapy has benefited other patients in similar circumstances.
- The expected frequency and length of time to complete the therapy.

The Program has most requests for experimental therapy reviewed by a third-party physician or specialist before making a decision. You must receive a written authorization from the Program before the Program will pay for the therapy and any associated costs. *The maximum payment is $6,000 per year unless otherwise specified.* A physician must periodically evaluate the participant's experimental therapy. For the Program to continue payments, the evaluation needs to show that the therapy continues to be medically beneficial. The Board of Directors may decide to consider other criteria as well.

Among the less traditional therapies that have been approved by the Program based on individual circumstances and physician recommendation are music, karate and conductive education.

See the checklist at the end of this section for the information needed to consider your experimental therapy request.

Program Review of Claims

Before authorizing payment for equipment or services, the Program may have any request reviewed by an independent medical professional to make sure the item is medically necessary and provides appropriate care for the participant.

Appealing Decisions

You may not always agree with the Program's decision on whether or not to cover a specific service or piece of equipment.

The Executive Director is your first level of appeal. If this person is unable to resolve the disagreement, the matter can be presented to the Board of Directors at its next regular meeting.

You may submit to the Board of Directors a written explanation of the dispute with any supporting documentation, such as letters of medical necessity, and the resolution you would like to see. You may also attend the meeting.

If the Board of Directors is unable to resolve the matter, you may file a petition of appeal with the:

Clerk of the Virginia Workers' Compensation Commission
333 East Franklin Street
Richmond, VA 23219

Appeals must be filed with the WCC within 30 days of receiving notification of the Board of Directors' decision.

Keep a copy of everything you send the Program

If you mail documents to us please keep a copy of each document. Also recommended is getting a Return Receipt from the U.S. Postal Service. The cost of this service will be reimbursed by the Program if you list it on the Claim Reimbursement Form.

Frequently Asked Questions

Q. How will I know if the Program changes its Regulations?

A. The Regulations change infrequently, however, if they are altered, all participants are generally notified. Additionally, a notice of proposed changes will be printed in the Virginia Register during a comment period. They also may be posted on our Web site at **www.vabirthinjury.com.**

Q. How do I keep abreast with what's going on with the Birth-Injury Program?

A. As needed, the Program communicates with all participants, usually by letter. Information is also posted on our Web site. All Virginia Birth-Injury Program board meetings are open to the public (however discussion of specific participant issues is held in closed session pursuant to confidentiality requirements of the Act). If you plan to attend a board meeting and speak with the board, while not required, we encourage you to notify the Executive Director in advance so you may be placed on the agenda and given sufficient time to speak.

Checklists – Working with the Program

Submit Claims

When submitting claims, you must send to the Program:

- ❑ Letters of medical necessity
- ❑ Proof of approval or denial by primary insurer and payment allowances listed on your insurer's Explanation of Benefits (EOB)
- ❑ Dated purchase receipts for all equipment and services
- ❑ Program forms as required (see specific benefits for details)
- ❑ A copy of your insurance policy's Evidence of Coverage (usually a booklet describing benefits)

Request Experimental Treatment or Therapy

Your letter to the Executive Director should include this information:

- ❑ The frequency and duration of the treatment, as well as the medical benefit it is expected to provide the participant.
- ❑ Overall cost. This includes the cost for one person to accompany the participant, if medically necessary.
- ❑ Where you can get the treatment, especially if you must travel a great distance from where you live. **Local providers must be used unless the Program grants an exception.**
- ❑ A report from the participant's physiatrist, neurologist, or other appropriate treating specialist physician must be received by the Program 60 days before treatment starts. It must describe the medical necessity for the participant to have the experimental treatment. Such a report from a physical therapist is not acceptable.
- ❑ Evidence showing whether the primary insurer(s) or other payers will cover any portion of the treatment.
- ❑ Documented medical proof that this treatment has benefited other people in similar circumstances. You may get this from the treatment provider, or do your own research using generally recognized and trusted medical sources. Clinical trials conducted by accredited medical facilities, medical schools, or other well-respected and medical accepted facilities or organizations, such as the American Medical Association, are acceptable. Anecdotal reports, personal testimonies, and similar reports may not substitute for accepted medical research.

How to Contact Us

Hours: 8:30 a.m. – 5:00 p.m.
Monday through Friday

7501 Boulders View Drive,
Boulders IV, Suite 210,
Richmond, Virginia 23225

Phone: 1-800-260-5352 or 804-330-2471
(see the positions listed below for extension numbers)

Fax: 804-330-3054

Web Site: www.vabirthinjury.com

E-Mail: first initial and last name @vabirthinjury.com. (Example: John Smith would be jsmith@vabirthinjury.com)

Staff

Contact the person specifically assigned to the area you have questions about. It will allow us to give you more efficient service.

Title	Can Help You With
Executive Director *Extension 3070*	• General Program questions • All requests for exceptions; issues not resolved by staff
Deputy Director *Extension 3020*	• Assistance regarding nursing agencies and independent caregivers • Setting up wage benefit programs • Information regarding Program audits and actuarial reports • Questions regarding annual claimant expenses paid reports • General financial inquiries
Accounts Payable *Extensions 3090*	• Reimbursement checks and related questions • Payment of invoices you submit • Setting up regular direct payments with vendors of services or supplies
Claims Manager *Extension 3060*	• Procedures for entering the Program • Status of claims with the Virginia Workers' Compensation Commission • Housing assistance benefits • Requesting and purchasing a van • Medically necessary transportation benefits

continued on next page

Title	Can Help You With
Billing Specialist *Extension 3030*	• Payments for medical services and therapy • Requests for diapers or other supplies
Administrative Assistant *Extension 3010*	• Assistance if you don't know whom to talk to • Request Program forms for caregivers • Mailing, faxing or emailing documents to the Program

Where to Find More Information

Program Web Site

Visit our Web site at www.vabirthinjury.com to find:

- Regulations and other key documents
- Schedule changes and the minutes of past Board of Directors' meetings
- Current legislation
- News and publications
- Links to other helpful resources
- Most required forms

Help from Families in the Program

We maintain a list of Program families willing to share their knowledge of how the Program works. Once each year, we seek new participants for this list. If you agree to participate, you can request and receive contact information of fellow list members. For confidentiality reasons, we cannot publish this list because this information, by law, is intended only for claimants who are admitted into the Program and agree to be listed.

Claim Reimbursement Form

The Claim Reimbursement Form is the central place to record all your expenses in any one month.

Use a separate form for each month and submit it to Accounts Payable along with receipts or verification forms for each item listed.

Forms are available on the Program's website. The form is also available as an Excel spreadsheet. After completing it, you may e-mail, fax or mail receipts and other supporting documents. Receipts must be sent for the form to be processed.

Keep a copy of everything you send the Program

If you mail documents to us, we also recommend getting a Return Receipt from the U.S. Postal Service. The cost of this service will be reimbursed by the Program if you list it on the Claim Reimbursement Form.

Claim Reimbursement Form

Claim Reimbursment Form

Admitted Claimant: _____

Month: _____

Virginia Birth-Related Neurological Injury Compensation Program

DATE	DESCRIPTION/PROVIDER/SERVICES/ITEMS	MILEAGE	AMOUNT
	Total Miles		
	Miles X Rate		$
	Subtotal		$
	Total Reimbursement		$

Signature & Date

Print Name

I certify that all the information given is accurate, that none of these items have been reimbursed by any other source for any amount, nor are they eligible for reimbursement from other sources.

Reviewed by

Mileage Reimbursment 2018	
Personal Car	$ 0.545
Program Van	$ 0.2725

Rev. 8/18

Medical Benefits

Dental Care

The Program will pay for the participant's dental care if he or she is not covered by any other source. Have your dentist make a copy of your Program card so the Program can be billed directly for any unpaid charges. This will limit your out-of-pocket expense.

If dental services are to be performed in a hospital, pre-authorization by the Program may be required. Contact us in advance to verify.

Family Counseling

The Program pays for counseling for family members on matters related to caring for the participant.

This service must be provided by a licensed clinical social worker (LCSW), counselor (LPC), psychologist, or psychiatrist.

Payment Limit

After primary insurance pays any covered expense, the Program will pay a maximum of $1,500 each calendar year for family counseling with a provider who is in the network of your primary care insurer.

There are no limits on the number of sessions or when you can schedule them. If total expenses are higher than the Program's $1,500 annual limit, you must pay the difference.

You may set up direct billing between the provider and the Program for the portion paid by the Program.

Prescriptions

The Program pays the cost of prescription medications not covered by insurance or other government programs. Utilize the Program Third Party Administrator RX card.

Any decisions as to whether a brand name or generic equivalent drug is most appropriate rests totally between the claimant, prescribing physician and your medical coverage insurers, including utilizing the insurer's appeals processes.

The Program is a payer of last resort

All expenses must first be submitted for reimbursement to other available payers. In some cases, your physician can work on your behalf directly with your primary insurer in submitting claims. Discuss this with your physician.

Frequently Asked Questions

Q. Do I have to use providers in my health insurance company's network?

A. The Birth-Injury Act states that the Program may not pay for any services that are contractually available to the participant through other health coverage policy. Therefore, if you go to a non-network provider and your health insurer refuses to pay for the service, the Program is not allowed to pay for the service.

Q. A provider in my health insurance company's network says I must pay for charges the insurance company does not pay for. Do I have to pay them?

A. As an "in-network" or contracted provider for your insurance company, the provider has a contract with the insurance company. The provider must abide by that contract. Any fees or co-payments not specifically allowed under your health insurance policy should not have to be paid by you or anyone else. The Program cannot pay any co-payments or fees not allowed under your insurance policy.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Checklist – Medical Benefits

To submit a claim for medical expenses to the Program after you have exhausted other sources of payment, you must provide appropriate documentation. This may include, but is not limited to, the following:

- ❑ Explanation of Benefits forms (EOB) from the insurance company
- ❑ Invoices
- ❑ Dated receipts that name the service or item purchased
- ❑ The Claim Reimbursement Form with the total expense entered on the line corresponding to the date of the expense
- ❑ For mileage, parking, and tolls reimbursement, a signed Verification Form for each visit to a medical facility. (See Medically Necessary Travel for more details.)

NOTE: The Program may require more than one type of documentation, depending on each situation and what specific information may be needed for thorough review, before approval can be given.

Hospital Benefits

Hospitalization

If a participant is hospitalized, all expenses should be submitted to insurers providing coverage. The Program will pay any approved charges that remain.

Have the hospital make a copy of your Program card so the hospital will have the information needed to submit any outstanding charges to the Program for payment. This will limit your out-of-pocket expense.

Private Duty Nurse

The Program does not provide a private-duty nurse when the participant is hospitalized. The Program cannot since hospital regulations do not allow non-hospital personnel to provide medical care. The Program may pay for an attendant if a physician's order is provided and approved by the Program.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Checklist – Hospital Benefits

To submit a claim for hospital expenses to the Program, you must provide appropriate documentation. This may include, but is not limited to, the following:

- ❑ The Claim Reimbursement Form with totals entered on the line corresponding to the date of the expense.
- ❑ Explanation of Benefits forms (EOBs) from your insurance company
- ❑ Invoices
- ❑ Dated receipts
- ❑ For mileage, parking, and tolls reimbursement, a signed Verification Form for each visit to a medical facility. *See Medically Necessary Travel* for more details.

NOTE: The Program may require more than one type of documentation, depending on each situation and what specific information may be needed for thorough review, before approval can be given.

Rehabilitation/Therapy

Therapy

The Program pays for therapy that is medically necessary and reasonable. A qualified physician must submit a written letter of medical necessity. Therapy providers may be required to submit treatment notes.

The Program may periodically have other independent medical professionals review the necessity of continuing any therapy program.

Therapeutic Toys

The Program will pay up to $300 (total cost including shipping, tax, etc) each calendar year for therapeutic toys. You must submit documentation from a physician or therapist that explains the benefit of these toys. After you receive approval from the Program, you may order the toys yourself and then seek reimbursement.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Checklist – Rehabilitation/ Therapy

To receive reimbursement for or payment of rehabilitation and therapy expenses, you must submit appropriate documentation. This may include, but is not limited to, the following:

- ❑ The Claim Reimbursement Form with the expenses listed on the appropriate date line
- ❑ For therapy, a letter of medical necessity from the primary care physician or specialist
- ❑ For therapeutic toys, an explanation from the therapist of how the participant will benefit from the toy
- ❑ Dated receipts or other proof of purchase for each service or item
- ❑ Explanation of Benefits (EOB) from insurance company

NOTE: The Program may require more than one type of documentation, depending on each situation and what specific information may be needed for thorough review, before approval can be given.

The Program is a payer of last resort

All expenses must first be submitted for reimbursement to other available payers. In some cases, your physician can work on your behalf directly with your primary insurer in submitting claims. Discuss this with your physician.

Experimental Treatment or Therapy

On a case-by-case basis, the Program may pay some expense for other treatments and therapies considered experimental that are not fully covered by health insurance. However, because this benefit is not provided expressly by the Virginia Birth-Related Neurological Injury Compensation Act, there is no guarantee of coverage.

To obtain preauthorization you must submit, at least 60 days before the desired start of treatment, a letter of medical necessity from the participant's physiatrist, neurologist, or other appropriate treating specialist physician and information regarding coverage by insurance or other sources.

(For a checklist of additional information you must provide, go to *Working with the Program – Requesting Experimental Treatment or Therapy.)*

The Program may have your request reviewed for medical necessity by an objective qualified physician.

Payment Limit

Experimental therapy expense and all related costs will be covered up to a maximum of **$6,000 each calendar year** unless other provisions apply.

Continuing Experimental Treatment or Therapy

If experimental therapy or other treatments extend or are received in an intensive fashion (such as several days in a row), the Program must receive a thorough progress report from the treating facility within 60 days of completion. No further sessions will be authorized until this report is received and approved.

The Program may have a qualified physician consultant complete an independent progress evaluation before authorizing subsequent treatments. If the participant's insurance will not cover this evaluation, the Program will pay for it and the cost will not be included in the total expense of the treatment.

If the treatment or therapy is provided sporadically or "a couple times a week" rather than for an extended/intensive period, the Program will authorize no more than 80 hours at a time.

Nursing, CNA, or other personal assistance will not be provided for sessions of more than two hours per day unless the treating specialist physician submits a letter of necessity stating that a nurse needs to be present due to specific health risks to the participant.

Residential/Custodial Care

Personal Nursing and Assistive Care

Why Use Nursing Agencies

When obtaining outside nursing or caregiver services, the Program recommends hiring through agencies. They are the most reliable way to get consistent, quality care. The Program can arrange to pay the agency directly to lessen your paperwork and out-of-pocket expense.

Nurses employed by agencies are covered under certain liability insurance if they are injured on the job. This means you do not have to buy similar coverage of your own.

All nursing agencies must provide the Program a certification that every employee hired to provide care to an admitted claimant has not been convicted of any offense considered a barrier crime according to Virginia Code §§ 37.2-314, 37.2-416, or 37.2-506.

If no agency can be found to provide appropriate care, the Program may approve alternative arrangements, which are explained below.

What is Covered

The Program covers medically necessary and reasonable nursing or assistive care when the participant's primary care physician submits a letter of medical necessity.

The Program's payment rates are in line with Medicaid payment rates, depending on the state or locality where care is provided.

Nursing Hours

- A full-time caregiver can be reimbursed for up to 40 hours per week unless extra time is authorized in advance by the Program.
- Caregivers may be reimbursed up to 16-hour shifts within a 24-hour period (but no more than 40 hours a week, unless pre-authorized). Extra hours are reimbursed only if there is an emergency and no other caregiver is available.
- The participant may have nursing care during school hours if it is medically necessary and no comparable care is available. These hours count toward the total approved weekly nursing hours. Please note that current law generally requires school systems to provide appropriate care for special needs children during school hours.

Changing Regular Nursing Hours

To have additional hours paid, the physician must submit an updated letter of medical necessity to the Program. A form for this is available.

Hiring Independent Contractors as Caregivers

When a nursing agency is not available, you may hire independent contractors as caregivers. This requires pre-approval from the Program.

Paying Independent Contractors

When you hire an independent contractor, you must pay that person yourself, as well as any unemployment or FICA taxes. To be reimbursed, submit Weekly Timesheets to the Program. Forms are available on the Program website.

The Program will reimburse unemployment and FICA taxes when you are able to provide canceled checks or a 941 form from your tax return.

The reimbursement hourly rate for caregivers is guided by data collected by the Virginia Employment Commission.

Get professional advice

We highly recommend that you talk with a tax professional, lawyer, or other qualified person to make sure you are obeying all applicable tax laws and regulations.

What is Not Covered

- The Program does not provide a private-duty nurse when the participant is hospitalized. The Program cannot since hospital regulations do not allow non-hospital personnel to provide medical care. The Program may pay for an attendant if a physician's order is provided and approved by the Program.
- Travel expenses are not paid for a nurse or caregiver to accompany the participant on vacations or other non-medically necessary travel.

Note: Respite care – or care provided to the claimant that is not for medically necessary purposes or for the claimant when normal caregivers are not available – is not a Program or legislatively provided benefit. However, the Program staff may be able to suggest sources for you to obtain such care from other organizations or agencies.

Avoiding Duplicate Reimbursement

If caregiver wages are reimbursed by the Program, you cannot file them as deductions or credits on your state and/or federal income taxes. Doing this would result in a double reimbursement that is not allowed by law.

Annual Review of Nursing Needs

The Program will generally contact the claimant's physician to obtain updated orders annually. The Program will work with you to adjust arrangements, if necessary.

Frequently Asked Questions

Q. How many nursing hours per day are paid for by the Program?

A. The participant's primary care physician usually determines the appropriate number of nursing hours required and the appropriate level of care (i.e., PCA, CNA, LPN, RN). A written order of medical necessity from the physician must be on file with the Program and a new written order is required for any increase in hours based on changes in medical condition. However, the Program reserves the right to review the medical necessity of the prescribed hours.

Q. How many hours per day may a nurse care for a participant?

A. Program Regulations stipulate that a nurse or caregiver should not work more than 16 hours per day (assuming the participant has written orders for the nursing care). This is primarily due to safety concerns.

Additional hours per day in some circumstances may be allowed due to a medical emergency, however, they should be pre-authorized by the Program if possible. For a medical emergency that occurs outside of normal working hours, please contact the Program as soon as possible afterward to determine if the hours were payable/reimbursable.

Also, please remember that daily nursing hours may not exceed the physician-prescribed daily hours.

Q. What happens if a nurse or caregiver works more than the prescribed number of daily hours?

A. The Program can only pay for the prescribed number of hours per day.

Q. Are nursing agencies always used to provide services to a participant?

A. Nursing agencies are an important method for obtaining services because of employment and tax issues and medical training, licensing, and liability issues. In some cases, the Program will allow families to hire their own nurses. However, it's important to note that in such situations the nurse or caregiver must meet the medical requirements as prescribed by the physician and must be an employee of the family, not the Program. If approved, the Program will reimburse the family for the cost of nursing services as approved by the Program. The Program will not pay the nurse or caregiver directly. Additionally, the family caregiver benefit is available.

All tax and employment issues are the responsibility of the participant's family in a reimbursement situation. We highly recommend that you consult with a tax professional, lawyer, or other qualified individual to ensure you are in compliance with all applicable laws and regulations.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Checklist – Residential/ Custodial Care

Step 1: Your Primary Care Physician…

Must submit to the Program a letter of medical necessity for nursing care, or he or she can complete a form available from the Program. The letter must include:

- ❑ Number of daily hours of care to be provided
- ❑ The level of care needed (personal care aide, CNA, LPN, RN)

Step 2: You…

Can get a list from the Program of qualified nursing agencies in your area. You must:

- ❑ Contact the nursing agency
- ❑ Interview possible nurses
- ❑ Make the hiring decision
- ❑ Notify the nursing agency of your choice

Step 3: The Nursing Agency…

Will contact the Program once you have selected a nurse to:

- ❑ Get authorization to provide the nursing care
- ❑ Sign an agreement with the Program

Step 4: You…

Must provide the Program with the following information to be reimbursed for caregiver expenses:

- ❑ Have the caregiver complete a Weekly Timesheet (whether you pay the person out-of-pocket or the Program pays the agency directly). The Timesheet must be signed by you and the caregiver.
- ❑ Submit the Weekly Timesheet, receipts and monthly summaries to the Program.
- ❑ To be reimbursed for taxes on the caregiver's wages, submit to the Program copies of canceled checks or Form 941 from your state/federal tax return when they are available.

The Program typically reimburses nursing expenses within 30 days of receiving your claim.

Family Caregiver Reimbursement

Requirements

Beginning July 1, 2008, the Program began issuing reimbursement for family members who provide medically necessary and reasonable nursing and attendant care for the claimant. This care must go beyond the scope of normal care an uninjured child would typically receive. To be eligible for reimbursement, family caregivers must be at least 18 years old. They must submit weekly timesheets and a monthly summary report, and may be required to provide receipts showing the amount paid for services.

The rate of reimbursement is based on the average hourly salary of a home health aide in the claimant's Metropolitan Statistical Area (MSA).

Before reimbursement can be approved, there must be a current prescription for care (less than one year old) on file with the Program.

Expenses That May be Reimbursed

The Program will reimburse an admitted claimant's parent or legal guardian for wages paid to a family member caregiver (which may include parents and legal guardians). In addition, the Program will reimburse any employment-related taxes paid, such as FICA or unemployment tax. You must provide documentation on these expenses to support all requests for reimbursement.

Applying for Reimbursement

Submit a current letter of medical necessity from the claimant's primary care physician or appropriate treating specialist physician providing details on the number of hours of care needed per day, the level of care required, and certification that the proposed caregiver is properly trained, qualified, and physically capable of providing the care.

For each family member caregiver for whom you want reimbursement, you must submit the following documentation to apply. Sample forms follow. Required forms are available on the Program's website.

1. Release and Waiver of Liability, Discharge, Convenant Not to Sue, and Indemnity Agreement of Admitted Claimant (notarized).

2. Release and Waiver of Liability, Discharge, Covenant Not to Sue, and Indemnity Agreement by Caregiver (notarized).

3. Certification, Waiver and Release Regarding Family Member Caregiver's or Independent Caregiver's Prior Criminal History. Note that this form has three versions and complete the one that's appropriate for your situation: two parents/guardians, single parent/guardian, or independent caregiver.

4. Family Member Caregiver Competency Certification.

Caregivers Not Eligible for Reimbursement

Each claimant's safety is a top priority, so certification that a background check has been completed is very important. No family member who has been convicted of an offense listed as a barrier crime, according to Virginia Code §§ 37.2-314, 37.2-416, or 37.2-506, can be hired as a claimant's caregiver.

The parent or legal guardian of the claimant is responsible for paying any application fees to obtain background checks. However, upon receiving the Criminal History Certification (a copy of the form to duplicate and use is in this Handbook), a receipt from the Virginia State Police, or an authenticated copy of the cancelled check for the fee, the Program will reimburse the fee expense when the person on whom the background check was run is actually hired and begins work.

Any disputes regarding barrier crimes may be appealed to the Program's Board of Directors by letter.

Submitting Timesheets

Each family member providing care to be reimbursed must complete one timesheet each week. A sample timesheet is available on the Program's website.

Each timesheet must be validated (signed) by another family member, according to the instructions given on the timesheet.

Each month, timesheets must be sent (mailed, faxed, scanned or e-mailed) to the Program no later than the 15th of the month following the time worked. For example, September timesheets must be sent to the Program by October 15 for monthly payment.

The Program will usually send the reimbursement check to the person validating the timesheet(s) although specific circumstances may allow, with Program approval, for other arrangements.

Submitting the Family Caregiver Monthly Care Summary

A Monthly Care Summary from each caregiver must be submitted with timesheets for each reimbursement request. For example, the Monthly Care Summaries submitted in October would accompany September timesheets and document the care provided in September.

Frequently Asked Questions

Q. How much will I be reimbursed per hour?

A. The reimbursement formula is the same for all family members providing care. However, the hourly amount varies based on where you live. It is the average hourly rate for a home health aide in your Metropolitan Statistical Area (MSA) as reported by the Virginia Employment Commission's state wage survey.

Q. How often will I receive the reimbursement?

A. The Program reimburses monthly if we receive the required documentation on time.

Q. How many hours may a family caregiver be paid for each week?

A. Up to 40 hours per week with no more than 12 hours per day/shift.

Q. Why is a Criminal History Certification required?

A. To assure the safety of claimants.

Q. Can these hours be added onto current nursing hours?

A. No. These hours are paid instead of prescribed nursing/caregiver hours.

Q. Does the family caregiver have to stay with the claimant for the hours reimbursed?

A. Yes, the family caregiver is expected to care for the claimant just as any caregiver hired through an agency would.

Q. Can I have the physician prescribe more caregiver hours to enable me to receive reimbursement?

A. No. The number of prescribed hours must be based solely on medical need noted in the Birth-Injury Act.

Q. After I qualify for reimbursement, what do I need to send in each time?

A. Weekly timesheets and a monthly summary report (forms for you to copy and use are in the Appendix of Forms), as well as receipts showing how much and when you paid a specific caregiver.

Q. Will receiving this reimbursement cause me to lose other benefits from state or federal sources?

A. It may. You will need to ask those who can advise you on these matters.

Q. Is the reimbursement taxable?

A. Probably. You will need to ask a tax expert.

Q. Will the Program report the reimbursement I receive to the U.S. Internal Revenue Service (IRS)?

A. It may. The Program continues to seek guidance from appropriate state and federal authorities.

Checklists – Reimbursement for Family Caregivers

Documentation Required To Gain Approval

- ❑ Letter of medical necessity from the claimant's primary care physician or appropriate treating specialist physician
- ❑ Family Member Caregiver Competency Certification – Completed by the claimant's physician and any other appropriate physicians
- ❑ Caregiver Liability Release – Completed by each proposed family member giving care
- ❑ Claimant Liability Release – Completed by the parent or guardian on behalf of the claimant
- ❑ Certification, Waiver and Release Regarding Family Member or Independent Caregiver's Prior Criminal History
- ❑ Weekly Timesheet
- ❑ Family Caregiver Monthly Care Summary

Caregiver Timesheet

Caregiver Timesheet

Please fill out the sheet completely and use only one sheet per week/per caregiver.

❑ Family Caregiver
❑ Independent Caregiver

Admitted Claimant:

Caregiver Name *(print)* SSN

For Week Ending *(month/day/year)* Hourly Rate: $

DAY	TIME IN	TIME OUT	TOTAL HOURS (Excluding Meals)
MONDAY	AM PM / AM PM	AM PM / AM PM	
TUESDAY	AM PM / AM PM	AM PM / AM PM	
WEDNESDAY	AM PM / AM PM	AM PM / AM PM	
THURSDAY	AM PM / AM PM	AM PM / AM PM	
FRIDAY	AM PM / AM PM	AM PM / AM PM	
SATURDAY	AM PM / AM PM	AM PM / AM PM	
SUNDAY	AM PM / AM PM	AM PM / AM PM	
		TOTAL HOURS	
		TOTAL INCOME: $ (Total Hours X Hourly Rate =)	

Caregiver Signature
NOTE: Original signatures required – no duplicates or copies.

I certify that all the information given is accurate and that none of the hours for which reimbursement is requested have been reimbursed by any other source for any of the amounts claimed.

Family Signature *(Cannot be the caregiver)*
NOTE: Original signatures required – no duplicates or copies.

I certify that the hours were worked, are accurate, and that I have paid the caregiver the total income for the pay period noted above.

Note: For single-parent caregivers, no family signature is required.

Virginia Birth Related Neurological Injury Compensation Program

Rev. 8/18

Family Caregiver Monthly Care Summary

Family Caregiver Monthly Care Summary

(Must be submitted at the end of each month with timesheets. Only one per claimant.)

General Information:
Month: Year:
Claimant's name:
Caregiver name: Relation:
Physician's name: Phone:

List medications and times given:
(Only list each medication once and the time(s) of day normally given. This is not a daily list, just a general description of medications and times given.)

1 5 9
2 6 10
3 7 11
4 8 12

Personal care given (circle method or fill in the blank):
Bathing: In bed In tub In shower
Feeding: By mouth By tube Pediasure (or other) # cans/day_____
Type of brand_____
Toileting: Passed urine Has catheter in place
Mouth/teeth care: Yes No
Turning: Every _____ hours
Exercise arms and legs every day: Yes No

Status:
Bowel movement: Yes No
Skin condition: Good, or red areas-location:
Sore, open areas-location:

List equipment being used:
1 4
2 5
3 6

If you need more space for any category above, please attach a second page.

Any comments for Nurse Case Manager?

Caregiver Signature: **Date:**

Housing Assistance

Modifying Your Privately Owned Home

If the participant has medically necessary housing needs that can be met in the home you own and occupy with the participant, the Program's Board of Directors will provide one-time funding for modification to, or construction of, an accessible bedroom and bathroom if it is reasonable to do so.

The modification must be within the Program's allowable standards for cost, space, and other factors. The Program's construction manager or other qualified professionals hired by the Program will decide whether or not the modification project is reasonable and will meet the participant's needs. All modifications must be completed at the same time.

Applicable federal and state standards for handicapped accessibility, when appropriate, will be utilized for planning, evaluation and implementation of all housing benefits.

Space Allowances for an Addition to Your House

- Bedroom: 16 ft. x 16 ft. = 256 sq. ft.
- Bathroom: 10 ft. x 10 ft. = 100 sq. ft.
- Storage space: 40 sq. ft.
- Total: 256 + 100 + 40 = 396 sq. ft.

Important: The modification contract is between you and the builder only and you are responsible for assuring all work is completed as required by plans and applicable laws and codes.

If required, the Program provides for a lift system to enter the home. If such a lift can be acquired through insurance or has already been acquired, the Program does not provide an additional lift.

If an elevator is approved and installed it is considered a part of the one-time housing benefit and all maintenance or other upkeep is the responsibility of the homeowner.

Rental Housing Assistance

If you and the participant live in rental housing, you may be eligible to receive rental assistance to move from a rental unit that is non accessible into a unit that complies with the accessibility guidelines of the Fair Housing Act.

Give Us Three Months' Notice

The Program asks you to provide information about your plans for rental housing at least three months before you make any changes. Without the Program's approval in advance, you may not receive rental housing assistance. It is not paid retroactively.

Space Allowance for a Rental Unit

Because it may be hard to find a rental unit that fits the Program's standard space allowance for a bedroom, bathroom, and storage area (396 sq. ft.), you can go up to 150 percent of these standards (594 sq. ft.) if the majority of that space is for the accessible bedroom, bathroom, and storage.

If the new rental unit has a higher cost per square foot than your current unit, the Program will allow up to 125 percent of the cost per square foot of the original rental unit.

Rental Subsidy Cost Calculation

This is how the Program calculates the square footage cost allowance for a rent subsidy:

Example: A family decides to move from their 1,000-square-foot apartment where they pay $1,000 a month into a larger 1,500-square-foot apartment that will cost $2,250 a month to provide accessible space for their child. This is how they determine the allowable amount of Program subsidy.

Step 1: Determine the increase in square footage.

Original Unit Square Feet	1,000
Proposed Unit Square Feet	1,500
(+)Increase/(–)Decrease	+ 500
Maximum Sq. Ft. Increase Allowed by Program	+ 594
Allowable Square Footage	**+ 500**

Step 2: Determine the cost per square foot.

Original Unit Cost	$1.00
Proposed Unit Cost	$1.50
(+)Increase/(–)Decrease per sq. ft.	+ $0.50
Increase as a Percentage of Original Unit Cost	150%
Maximum % of Original Unit Cost Allowed by Program	125%
Allowable Cost per Square Footage (125% × $1.00)	**$1.25**

Step 3: Multiply the allowable square footage by the allowable cost per square foot.

500 sq. ft. × $1.25 = $625 per month rental subsidy

This is the amount the Program will provide as a subsidy each month.

Maximum Lifetime Housing Assistance Benefit

Up to $175,000 per participant for any one benefit, or a combination of housing construction modification (one time) and rental.

Important Note: The Birth-Injury Act does not stipulate or provide for any housing benefit except when a participant is placed in a residential facility. However, the Board of Directors of the Program provides a benefit. It is outlined here and in the Program Regulations, which you can find on our Web site at **www.vabirthinjury.com.**

Frequently Asked Questions

Q. What housing-related benefits does the Program provide?

A. The Birth-Injury authorizing legislation does not stipulate any housing benefit except when a participant is placed in a residential facility. However, the Board of Directors of the Program provides a benefit. It is outlined here and in the Program Regulations, which you can find on our Web site at **www.vabirthinjury.com.**

Q. Will the Program make accessibility-related modifications to my residence?

A. Generally, yes.

Q. Does the Program have a housing benefit if I rent?

A. Yes. In May 2004, the Board of Directors approved such a benefit. Essentially, if a participant moves into a rental unit that is compliant with Fair Housing Accessibility Standards and of similar size and quality to the former rental unit, the Program will pay the difference attributable to the accessible bedroom and bath. However, there is a lifetime benefit maximum of up to $175,000, and other restrictions and guidelines apply. They are discussed in this handbook and in the Program Regulations available on our Web site at **www.vabirthinjury.com.**

Q. I understand the Birth-Injury Program once provided houses for participants. Is that still its policy?

A. In its early years, the Program provided "Trust Homes" for participants. These homes were owned by the Program and provided for participants' use.

Additionally, for a short period, the Program provided "Cash Grants" for use in purchasing or building a suitable residence for the participant.

Mainly because of financial considerations, both of these policies are no longer in effect, and the current benefit is explained in this handbook and in the Program Regulations, available on our Web site at **www.vabirthinjury.com.**

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Checklists

Process for Modification of Privately Owned Home

- ❑ Contact the Program's Claims Manager
- ❑ Program will schedule on-site consult with construction manager
- ❑ Preliminary design and plans for addition drafted by Program
- ❑ If special permits, zoning waivers or other unusual authorizations are needed from city/county government, these must be obtained prior to proceeding
- ❑ Review of plans by family and construction consultant, modification as needed
- ❑ Family secures three bids from contractors (assistance usually available, bids must be within Program allowances, additional costs must be paid by homeowner
- ❑ Scope, budget and schedule documents developed
- ❑ Obtain the Building Agreement, sign and return to Program
- ❑ Authorization from Program for construction
- ❑ Family signs contract with builder
- ❑ Construction begins/ends based on builder's and homeowner's agreement
- ❑ Punch list (things to be fixed) and occupancy
- ❑ Construction closeout

It is the Program's experience that construction from planning to completion can take from 6 to 24 months depending on the scope of the project, need for government licenses and waivers and your builder's schedule. In some cases the process has taken considerably longer primarily due to difficulty in obtaining needed permits or waivers. While the Program can often lend assistance, it is the homeowner's and builder's responsibility to obtain all needed permits.

Any changes requested by the homeowner once construction begins will be solely the responsibility of the homeowner, including any additional costs and/or penalties imposed by the builder.

The modification contract is between you and the builder only and you are responsible for assuring all work is completed as required by plans and applicable laws and codes.

Rental Assistance

To be reimbursed for any difference in the cost of the new rental unit, it must meet these Program standards:

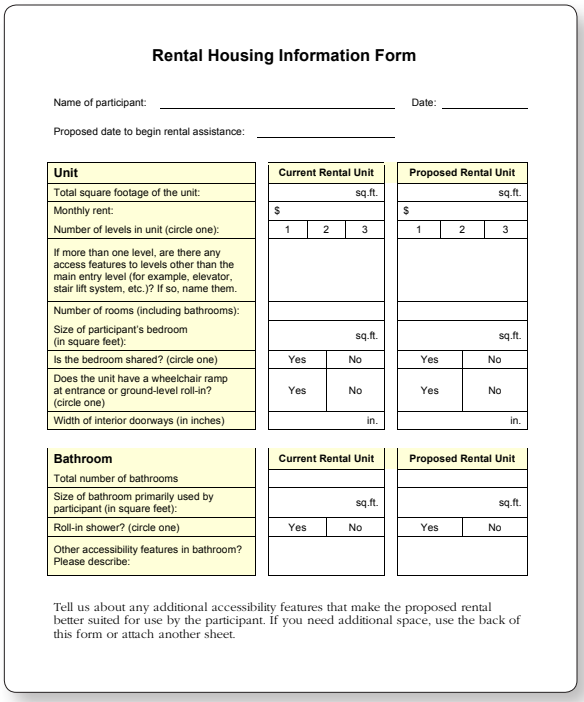
- ❑ It must be similar to the previous unit in size and quality based on the cost per square foot.
- ❑ Any major increase in the square footage of the new unit must be due to the medical needs of the participant.
- ❑ The increase in square footage must not be greater than the Program allows when constructing a modification to an owned home.
- ❑ Any exceptions must be approved by the Program's Board of Directors. The Program may require that the unit be professionally certified for compliance with the participant's medical needs.

When you request rental housing assistance, submit the following documents to the Claims Manager:

- ❑ Rental Housing Information Form (a form to duplicate and use is at the end of this section)
- ❑ Any additional information on accessibility features that make your proposed rental unit more suitable for the participant than his or her present residence
- ❑ Copy of your current rental agreement
- ❑ Copy of the new rental agreement for the unit you are proposing
- ❑ Floor plan of the new rental unit (you should be able to get one from the rental agent)
- ❑ Floor plan of your current rental unit (if available)

Be sure to submit only copies of all documents. Keep the originals in a safe place.

Rental Housing Information Form



Rental Housing Information Form

Name of participant: _____ Date: _____

Proposed date to begin rental assistance: _____

Unit	Current Rental Unit	Proposed Rental Unit
Total square footage of the unit:	sq.ft.	sq.ft.
Monthly rent:	$	$
Number of levels in unit (circle one):	1 2 3	1 2 3
If more than one level, are there any access features to levels other than the main entry level (for example, elevator, stair lift system, etc.)? If so, name them.		
Number of rooms (including bathrooms):		
Size of participant's bedroom (in square feet):	sq.ft.	sq.ft.
Is the bedroom shared? (circle one)	Yes No	Yes No
Does the unit have a wheelchair ramp at entrance or ground-level roll-in? (circle one)	Yes No	Yes No
Width of interior doorways (in inches)	in.	in.

Bathroom	Current Rental Unit	Proposed Rental Unit
Total number of bathrooms		
Size of bathroom primarily used by participant (in square feet):	sq.ft.	sq.ft.
Roll-in shower? (circle one)	Yes No	Yes No
Other accessibility features in bathroom? Please describe:		

Tell us about any additional accessibility features that make the proposed rental better suited for use by the participant. If you need additional space, use the back of this form or attach another sheet.

Accessibility

The U. S. Fair Housing Act has seven items you should consider when looking for a new rental unit. However, the unit does not have to meet all of these conditions for you to receive rental assistance from the Program. This checklist is provided only for your assistance.

Accessible entrance from an accessible route unless it is impractical to have one.

Accessible public and common-use areas.

Doorways that provide at least 32 inches of clearance for wheelchair access.

Accessible routes into and throughout the unit.

Accessible light switches, electrical outlets, and environmental controls (such as for heating, air conditioning).

Reinforced walls in the bathroom.

Adequate space for wheelchair accessibility in the kitchen and bathroom.

Special Equipment

Types of Equipment Provided

The Program will generally purchase equipment for the participant if the physician submits a letter of medical necessity. Pre-authorization is generally required. The Program may have such letters reviewed by another physician to confirm the request. All equipment requests must be submitted to your insurer and if applicable purchased through the insurer's provider network.

It is impossible to list every type of equipment on the market that may be proven medically necessary. However, the following items are examples of equipment we have provided in the past when appropriate:

- oxygen concentrators
- IV poles
- pulse oximeters
- bipap machines
- feeding pumps
- therapy balls and mats
- wheelchairs
- wheelchair lifts
- apnea monitors
- gait trainers
- suction machines
- wheelchair tie-downs

Pre-authorization from the Program is required when the Program will be the primary payer for equipment or services.

Augmentative Communication Technology

The Program also pays for devices, equipment, and computer software that aids communication if the participant is unable to communicate verbally. The participant may need to be evaluated by a qualified specialist. This is to ensure that the correct equipment is purchased. All equipment requests must be submitted to your insurer and if applicable purchased through the insurer's provider network.

The Program expects the participant and all caregivers to learn how to use the equipment so it serves its intended purpose.

Ownership of Equipment

All equipment (except vans) purchased entirely by the Program is the property of the Program.

Return of Equipment

If the equipment is no longer needed and is in good condition, please check with the Program to see if it should be returned. In most situations the Program no longer requires equipment to be returned and recommends it be donated to a worthy cause.

If the Program did not pay the total expense for the equipment, it does not have to be returned.

Frequently Asked Questions

Q. How do I purchase medical equipment?

A. Since the Program is a payer of last resort, you must first submit the expense to your primary health insurer. If the Program pays some of the expense, we must authorize any equipment purchase and receive a letter of medical necessity or a physician's order along with a description of the equipment.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Checklist – Special Equipment

- ❑ First, submit the physician's order for purchasing the equipment to your insurance company or any other program that may cover the expense.
- ❑ After your insurer has processed the request and sent you an Explanation of Benefits form (EOB) or similar information, send to the Program the EOB and a physician's letter of medical necessity.

Vehicle Benefit

The Program pays for the purchase of wheelchair-accessible vans for participants who are wheelchair-dependent and need medically necessary transportation.

Some participant size requirements may apply before a Program-purchased van is available.

A participant who can walk can be transported by regular means, such as by car, and is not eligible for a Program supplied van.

When considering your handicapped accessible transportation needs, please keep in mind your overall requirements. For example, if you require seating for more than six or seven people total, and growth in future wheelchair size, a minivan may not be appropriate. Please talk with the Claims Manager if you desire assistance determining which vehicle is most appropriate for you.

Important: Wheelchair size and shape must be considered when obtaining a van to assure the van will adequately accommodate the current and future wheechairs.

Program Vans

There are two van options for families to consider once it has been determined that the participant is wheelchair-dependent and requires a wheelchair accessible van. These options are as follows:

1. The Program will provide a standard mini-van equipped with manual wheelchair tie-downs and a manual wheelchair lift or ramp. This option requires no out-of-pocket cost to the family, unless they go through the dealership to obtain additional non-standard options. These options would be paid for by the family directly to the dealer.
2. The Program will provide an amount of money equivalent to the cost of the standard van noted above, allowing the family to choose another type of wheelchair-accessible van. Most often this is a modified mini-van such as a Dodge or Chrysler, Chevrolet or Ford. This vehicle must be approved by the Program before the funds will be released. All monies must be paid directly to the dealer.

The Program's van agreement, which requires the Program to be listed as the primary lien holder, must be completed before delivery of a van. In situations where a van previously purchased by the Program is being replaced, this van must be released to the Program at the time the family takes possession of the new van. The family is not entitled to retain the funds received for trade-in of an old van, nor can this value be added to the allowable amount for van purchase. Proceeds from the sale of returned vans are placed in the Program's resources.

Options Included

The Program pays for power mirrors, locks and windows.

Buying a Van

The Program Claims Manager can recommend van dealers and answer questions. Often, the Claims Manager can locate an appropriately modified mini-van that is available with little or no additional cost to you (but this is not guaranteed). However, we also encourage you to work directly with your van dealer.

Additional Ways to Buy a Van

Occasionally, the Program is asked if it is allowable for the family to utilize the van benefit to purchase a "used" or "pre-owned" handicapped-modified van. This may be approved with the following provisions:

- The 100,000 mile requirement before replacement will be added onto the mileage at purchase. For example, if the van purchased already has been driven 10,000 miles, the van would not be eligible for replacement by the Program until it reaches 110,000 miles on the odometer.
- A special waiver must be signed stating that it was the participant family's choice and desire to purchase a pre-owned van and that you understand all other provisions of purchasing such a van.

Other Requirements

Van Agreement

A Van Agreement (contract) must be signed by the participant family prior to any money being supplied by the Program. This agreement outlines the responsibilities of the Program and the family. Go to the Appendix of Forms to read the agreement.

Ownership

The van will be titled in the family's name, which means legally you own the van.

The Program will maintain a first lien on the van and will hold the van's title documentation.

Maintenance and Repair

You are responsible and required to perform all required routine maintenance and required repairs.

Van Replacement

Vans will be replaced upon reaching 100,000 miles.

Personal Investment

If you invested in optional features during the purchase of a van being returned to the Program, you may receive a prorated refund of your investment based on the actual sales value of the returned van.

Return of the Van

Once the requirements are met for obtaining a new van (after 100,000 miles), the old van must be returned to the Program in good working order and be able to pass a Virginia state inspection. Returned vans are sold and the proceeds are returned to the Fund.

Purchase – Instead of returning a van, you may purchase it from the Program if an agreement on the price is reached with the Program.

If the van becomes unnecessary for transportation of the participant for any reason, you must transfer the title of the van to the Program and return the van within 90 days.

What Van Expenses are Covered

The Program pays annual personal property taxes. You are responsible for the cost of any county or city decal fees, whether they are billed separately or with the personal property taxes.

The Program annually pays an amount equal to the Uninsured Motorist Fee ($500) or the insurance premium for the van, whichever is less. You must request payment.

Mileage for medically necessary travel is reimbursed. See *Medically Necessary Travel* for details.

The Program reimburses the cost for insuring the lift, tie-downs, or other additional charges for handicapped modifications if you timely submit a receipt for the additional insurance.

Your Responsibilities

- You must pay any costs associated with registering the van, such as licenses, registration, city/county decals and tags.
- You must have all required maintenance performed to keep the van running.
- You must pay for all required maintenance, repairs, and ordinary parts that must be replaced, such as windshield wipers and tires.
- You are highly recommended to maintain a detailed written record of all maintenance and service work performed.
- You must buy vehicle insurance coverage which should include coverage for the handicapped modifications. The Program will reimburse up to $500 a year.
- If you want any non-standard van options, you must negotiate with the dealership and pay for them directly.
- The Program provides a van to safely transport the participant. The van may not be used for hauling or other business purposes.
- You may never lease or rent the van to others.

How to Receive This Benefit

To qualify for a van, the participant must primarily utilize a wheelchair. Infants are generally not eligible to receive a van.

The participant's physician must submit an order for a van to the Claims Manager. You must sign and submit the Van Agreement.

Frequently Asked Questions

Q. When is a participant eligible for a van?

A. Generally, when a van becomes medically necessary for wheelchair transportation.

Q. When does the Program replace vans?

A. A van paid for by the Program will be replaced when it reaches 100,000 miles. However, other factors will be taken into consideration, including the vehicle's service history. It works much like a warranty situation, so you should keep all records of service on the van to back up any concerns.

Q. Do I have to return the old van to the Program?

A. Yes. The returned van must be in good running condition, with only reasonable and normal body wear, and it should pass a Virginia state inspection. Returned vans are sold and the proceeds are returned to the Birth-Injury Fund.

Q. What happens if the Program supplied van is wrecked?

A. You must maintain adequate insurance on the van and utilize that insurance for repairs or equivalent replacement. The Program is not liable for repairs or replacement of a wrecked van.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Checklist – Vehicle

- ❑ Submit your physician's written order for a van to the Program Case Manager.
- ❑ Sign the Program Van Agreement. (Go to the *Appendix of Forms* for an Agreement to duplicate and use if forms have not been provided. To be included only if the Program includes the samples with the disclaimer.)
- ❑ Submit proof of insurance.
- ❑ Return the van title to the Program after the van is registered.
- ❑ As long as you have the van, keep all dealership and/or repair shop receipts or diagnostic paperwork so you can provide a history of the van's service should it be required.
- ❑ Receive written Program authorization prior to taking possession of the van.
- ❑ All handicapped accessibility equipment or modifications should be installed or completed prior to taking possession of the van.

Medically Necessary Travel

The Program reimburses for mileage, parking, and tolls associated with transporting the participant to medically necessary destinations.

Examples of Medically Necessary Destinations

- Medical appointments at a hospital or physician's office
- Therapy sessions

Non-Medical Destinations Not Covered Include:

- School
- Social activities
- Appointments not related to health care
- Vacation travel
- Routine errands, such as picking up prescriptions or DME, with or without the participant

Reimbursement Rates

If you have a Program van, mileage is reimbursed at 50 percent of the federal (IRS) standard mileage rate for vans because the Program provides the van itself.

You can usually find the current federal reimbursement rate at **www.irs.gov.**

If you don't have a Program-supplied car and use your personal vehicle, mileage is reimbursed at the full federal IRS rate.

If you have to use some other form of transportation not normally paid by the Program, please submit your receipts for consideration of reimbursement. If taxi service is utilized it must be for short distances, generally less than 10 miles.

Travel More than 100 Miles

If you must take the participant for healthcare-related treatment more than 100 miles from the participant's primary residence, you must obtain written pre-authorization from the Program. Without authorization, the Program may not pay the travel-related expenses. Requests should be submitted at least 14 days in advance.

Lodging and Meals Reimbursement

Reimbursement for lodging and meals is on a per diem basis (an amount for each day that has a fixed maximum). The Program uses the per diem amount established by the Commonwealth of Virginia. The Program allows reimbursement for the claimant and one parent/guardian.

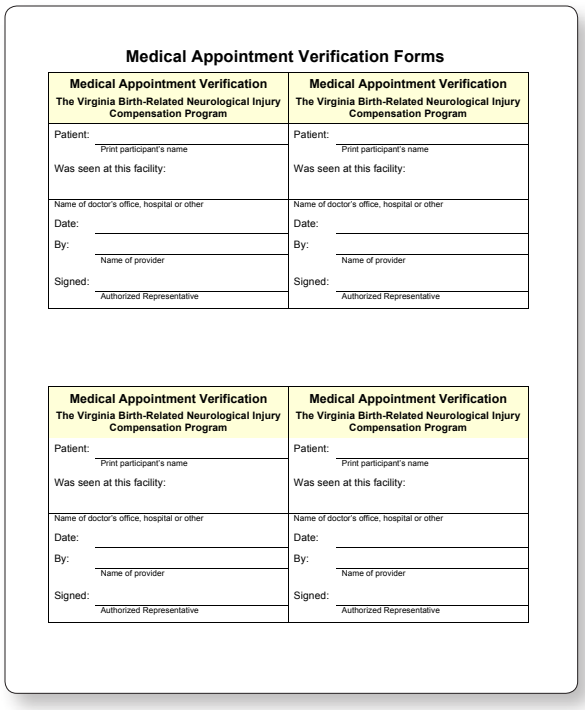
Checklist – Travel Reimbursement

Reimbursable mileage is the distance between the participant's home and healthcare-related appointment locations.

- ❑ If the appointment is more than 100 miles away, you must first receive pre-authorization from the Program.
- ❑ During the appointment, have the physician fill out the Medical Appointment Verification Form. You may list several appointments on one form in a 30-day period. (Forms to duplicate and use are at the end of this section.)
- ❑ On the Claim Reimbursement Form, on the appropriate date line, enter the miles driven in the "Mileage" column. Enter parking and tolls next to the appropriate date line.
- ❑ Mail, fax or email your Verification Forms, receipts, and Claim Reimbursement Form to the Program.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Medical Appointment Verification



Medical Appointment Verification Forms

Medical Appointment Verification The Virginia Birth-Related Neurological Injury Compensation Program	Medical Appointment Verification The Virginia Birth-Related Neurological Injury Compensation Program
Patient: _____ (Print participant's name) Was seen at this facility: _____ (Name of doctor's office, hospital or other) Date: _____ By: _____ (Name of provider) Signed: _____ (Authorized Representative)	Patient: _____ (Print participant's name) Was seen at this facility: _____ (Name of doctor's office, hospital or other) Date: _____ By: _____ (Name of provider) Signed: _____ (Authorized Representative)

Medical Appointment Verification The Virginia Birth-Related Neurological Injury Compensation Program	Medical Appointment Verification The Virginia Birth-Related Neurological Injury Compensation Program
Patient: _____ (Print participant's name) Was seen at this facility: _____ (Name of doctor's office, hospital or other) Date: _____ By: _____ (Name of provider) Signed: _____ (Authorized Representative)	Patient: _____ (Print participant's name) Was seen at this facility: _____ (Name of doctor's office, hospital or other) Date: _____ By: _____ (Name of provider) Signed: _____ (Authorized Representative)

Other Benefits

Cell Phones

The physician must write a prescription and submit it to the Program stating that the phone is a medical necessity.

The Program covers basic monthly emergency service, if it is available, or up to $25 a month for regular service. No charges for minutes will be covered unless a verified medical emergency necessitated the charges.

Diapers

Beginning at age three, the Program pays for diapers if they are medically necessary and your health insurance or other programs will not cover the expense.

If the Program pays for diapers, we can often arrange regular deliveries and pay the diaper service directly to save you time and out-of-pocket expense.

If you must purchase diapers, submit dated receipts with your Claim Reimbursement Form showing the total expense on the correct date line.

Funeral Expenses

The Program pays a maximum of $5,000 for funeral and burial expenses. You may submit receipts for reimbursement or contact the Program for direct billing.

Postage

The Program pays postage expenses for:

- Postage you pay to mail receipts and forms for reimbursement requests.
- Postage you pay to mail information the Program asks you to provide.
- The cost of Return Receipts you purchase from the Post Office to verify delivery of documents to the Program.

Submit the expense on the Claim Reimbursement Form on the correct date line.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Reasonable Claim Filing Costs

Reimbursement for Attorney's Fees

Under Virginia law, the Program may cover reasonable attorneys' fees you pay to get help in filing an initial claim to have a child accepted into the Program.

The child must be accepted into the Program by the Workers' Compensation Commission (WCC) for you to qualify for reimbursement of attorney's fees.

The WCC determines the amount that may be reimbursed for legal fees.

Important Note: This handbook is intended solely to provide summaries and practical information about benefits provided to admitted participants of the Virginia Birth-Related Neurological Injury Compensation Program. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with the Program Regulations and the Virginia Birth-Injury Act.

Compensation for Lost Earnings

A participant may be eligible for compensation for lost earnings when he or she reaches age 18 and until age 65.

The Program provides one-half of the average Virginia weekly wage for work in the private, non-farm sector.

This benefit is paid in monthly installments.

Please see the informational sheets in the appendix or contact the Program for further information.

Glossary of Terms

Authorization: Written approval to have a therapy, program, service, equipment provided, with the expense paid. Authorization may be needed from your primary insurer, the Program, or both.

Barrier Crime: Virginia Code §§ 37.2-314, 37.2-416, and 37.2-506 define a wide variety of offenses. You can look them up on the Internet for specifics.

Cognitively disabled: Having difficulty reasoning and forming thoughts.

Co-payment: The share of the charges you must pay to a provider of health care services.

CNA: Certified nursing assistant

Deductible: A specific dollar amount you must pay for covered services before your primary insurer will pay the rest of the expense.

DME: Durable Medical Equipment

Experimental treatment or therapy: A treatment or therapy not currently approved for use by the Program.

Inpatient care: Also called acute care. This is round-the-clock care a participant receives in a health care facility under the care and direction of an attending physician.

LMN: Letter of Medical Necessity

LPN: Licensed practical nurse

Medically necessary: This is care that is needed to treat a medical condition. It is required for reasons other than convenience, it is the most appropriate care for the situation, and it is provided when no other care would be more efficient, inexpensive, or effective.

Motorically disabled: Having difficulty with movement.

Network services: Services provided by a facility or health care provider that is approved by your primary insurance company. The provider must be on the list of approved providers when you receive the service.

Out-of-network services: Services provided by a facility or health care provider that is not on the list approved by your primary insurance company. You may have to pay a greater portion or all of the charges for services you get out-of-network.

Payer of last resort: The entity responsible for paying any expense left after all other ways of getting it paid have been exhausted. The Birth-Related Injury Program is typically the payer of last resort.

PCA: Personal Care Aide

Preauthorization: This is when you receive permission before you buy goods or services. It may also involve receiving a referral to the appropriate provider who can help you.

RN: Registered Nurse

TPA: Third Party Administrator

Treatment plan: Therapy or programs requested by you or your physician that are intended to help the participant.

VIRGINIA BIRTH-RELATED
NEUROLOGICAL INJURY
COMPENSATION PROGRAM

Phone: 804-330-2471

Fax: 804-330-3054

7501 Boulders View Drive

Suite 210

Richmond, VA 23225

www.vabirthinjury.com

www.vabirthinjury.info

A lifetime of help