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Annual Survey of Virginia Law: Health Law

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HEALTH LAW

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I. INTRODUCTION

During the past year, the Commonwealth of Virginia has experienced numerous developments in health law on all three major legal fronts—legislative, judicial, and administrative law. These developments have covered a range of health law topics, including everything from revisions to the public certificate of need process for health care facilities and the regulation of body-piercing of minors on the legislative front, to key decisions regarding the scope of the Virginia Birth-Related Neurological Injury Compensation Act¹ and the Health Care Decisions Act² on the judicial front, to action on the regulatory front regarding independent external appeals of health plan denials and hospice care under the Medicaid program. This article offers a summary of some of the most significant developments in health law in each of these three legal arenas during the past year.

II. LEGISLATIVE DEVELOPMENTS

The legislature tackled a number of health law issues of importance in its most recent session. This summary touches on some of the most important pieces of legislation considered by the legislature, including some items which were defeated or carried

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1. VA. CODE ANN. §§ 38.2-5000 to -5905 (Repl. Vol. 1999 & Cum. Supp. 2000).
2. *Id.* §§ 54.1-2981 to -2993 (Repl. Vol. 1998 & Cum. Supp. 2000).

over until the next legislative session. Among those "hot button" issues which were considered by the legislature, but not passed and signed by the Governor, were the right of a patient to sue an HMO, the confidentiality of medical records, and restrictions on abortions. These items are included in this article because of their significance as issues of public policy and as a comparative tool in assessing Virginia's health law and policy in light of legislative and regulatory action by both the federal and other state governments.

A. *Public Health Issues*

1. Organ Donations

The national system for organ donation, procurement, and allocation is regulated by the federal government.³ Virginia, in legislation enacted this year, established requirements for Virginia hospitals to incorporate the federal guidelines for organ donation, procurement, and allocation into existing processes for organ donation and procurement.⁴ Each hospital is now required to establish an organ donation and procurement protocol that addresses issues related to compliance with the federal Health Care Financing Administration ("HCFA") regulations.⁵ Each hospital must also execute "an agreement with an organ procurement organization designated in HCFA regulations."⁶ This agreement must provide that the hospital will notify the organization "in a timely manner of all deaths or imminent deaths of patients in the hospital" and that the organization "is authorized to determine the suitability of the decedent or patient for organ donation."⁷

Additionally, this legislation requires hospitals to collaborate with organ procurement organizations to inform deceased patients' families of the option of making or declining to make organ donations.⁸ This process of informing the family must involve staff appropriately trained in approaching and discussing organ

3. See 42 C.F.R. pt. 121, § 482.45 (1999).

4. See VA. CODE ANN. § 32.1-127(B)(4) (Cum. Supp. 2000).

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

donation with families of deceased patients.⁹ All applicable hospital staff must be educated as to proper procedures for organ donation, review of deceased patient records with regard to identifying potential donors, and preservation of the donor while necessary testing and placement of donated organs is effectuated.¹⁰

The law also clarifies the means and effect of organ donation declarations or refusals by a patient prior to death and the effect of such statements after death.¹¹ Organ donation may now be expressed in an advance directive, as indicated in the Health Care Decisions Act,¹² in addition to the previously allowed document of gift or documentation on file with the Department of Motor Vehicles.¹³ The donation is effective upon the death of the donor and becomes irrevocable at that time—the concurrence or objection of the family or any other person notwithstanding.¹⁴ Prior to death, the donor may revoke the gift or donation at any time by following the proper procedure for revocation based on the means of the gift.¹⁵

2. Body-Piercing

This year the legislature also tackled the issue of body-piercing by passing a law aimed at authorizing localities to regulate sanitary conditions of establishments that perform body-piercing and prohibiting the body-piercing of minors except under certain supervised circumstances.¹⁶ Body-piercing is defined as “the act of penetrating the skin to make a hole, mark, or scar, generally permanent in nature.”¹⁷ The legislature excluded from this definition “the use of a mechanized, presterilized ear-piercing system that penetrates the outer perimeter or lobe of the ear.”¹⁸

The law makes the act of body-piercing a minor illegal except when done in the presence of that minor’s parent or guardian, or

9. *Id.*

10. *Id.*

11. *Id.* § 32.1-290 (Cum. Supp. 2000).

12. *Id.* §§ 54.1-2981 to -2993 (Repl. Vol. 1998 & Cum. Supp. 2000).

13. *Id.* § 32.1-290(B) (Cum. Supp. 2000).

14. *Id.* § 32.1-290(E) (Cum. Supp. 2000).

15. *Id.*

16. *Id.* § 18.2-371.3 (Cum. Supp. 2000).

17. *Id.*

18. *Id.*

when done by or under the supervision of licensed medical personnel, such as a doctor or registered nurse.¹⁹ A violation of this prohibition is a Class 2 misdemeanor.²⁰

3. Immunizations

In order to promote child immunization and health, the legislature enacted a measure aimed at reducing barriers to immunization.²¹ To achieve this end, the legislature expanded the means by which immunizations may be obtained by allowing registered nurses, in addition to physicians and employees of local health departments, to administer them to school children.²² In addition, the law eliminates the requirement that a physician or registered nurse who certifies that public school employees have been tested for, and are free of, tuberculosis, be an employee of the local health department.²³

4. Abortion

a. Informed Consent Requirements

The legislature failed to pass a proposed law (originally introduced in the House of Delegates) that would have required written informed consent from a patient at least twenty-four hours prior to an abortion being performed.²⁴ The proposed law required that the physician, or his or her agent, who was to perform the procedure, obtain the consent no less than twenty-four hours prior to the procedure.²⁵ The legislation outlined the information that would have been necessary to constitute "informed" consent.²⁶ This information included: (1) a full, reasonable and understandable medical explanation of the nature, risks, and bene-

19. *Id.*

20. *Id.* A Class 2 misdemeanor is punishable by "confinement in jail for not more than six months and a fine of no more than \$1,000, either or both." *Id.* § 18.2-11(b) (Repl. Vol. 1996).

21. *Id.* § 22.1-271.2 (Repl. Vol. 2000).

22. *Id.* § 22.1-271.2(A) (Repl. Vol. 2000).

23. *Id.* § 22.1-300 (Repl. Vol. 2000).

24. H.B. 1482, Va. Gen. Assembly (Reg. Sess. 2000).

25. *Id.*

26. *Id.*

fits of the procedure and the alternatives to the procedure for that particular case; (2) instruction to the patient that she may withdraw consent to the procedure at any time prior to the procedure; (3) informing the patient that she may speak with the performing physician and ask any questions and obtain any additional information about the procedure; (4) a statement of the probable gestational age of the fetus at the time the procedure is to be performed; and (5) provision of printed materials which provide certain objective information.²⁷ The information would have to include: (1) alternatives to abortion and community resource information regarding adoption, paternity establishment and child support enforcement, child rearing, pediatric and maternal health care among other areas; (2) the nature of the abortion procedure and techniques used in the procedure; and (3) the nature of fetal development and characteristics of the fetus throughout pregnancy.²⁸ The proposed law did make an exception for abortions required in a medical emergency to save the life of the mother or to prevent substantial and irreversible impairment of a bodily function of the mother.²⁹ The law proposed a civil fine of \$2,500 upon any physician who failed to comply with the requirements of the law.³⁰

b. "Unlawful Abortion"

A similar bill was introduced in the Senate that required written informed consent in abortion cases and, in addition, added provisions related to the crime of "unlawful abortion."³¹ The crime of "unlawful abortion" was to be a violation of Virginia Code section 18.2-76, which contains the written informed consent requirement as contained in both the House and Senate legislation.³² The bill would have vested jurisdiction over a trial involving allegations of a violation of the written informed consent requirement in the general district courts.³³

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. S.B. 781, Va. Gen. Assembly (Reg. Sess. 2000).

32. *Id.*; Va. H.B. 1482.

33. *See* Va. S.B. 781; Va. H.B. 1482.

B. *Patient Rights and Protection Issues*

1. Consent to Treatment and Transport of Minors in an Emergency

The legislature modified the statute with regard to the consent to treatment of minors to allow for certain exceptional circumstances.³⁴ The revised statute now allows for transport of a minor by emergency personnel without consent where a delay in transporting the minor from the scene of an accident, fire, or other emergency prior to hospital admission may adversely effect the minor's health.³⁵

As written, the law states that a person authorized to give consent must not be available within a reasonable period of time under the circumstances.³⁶ If the person authorized to give consent can be reached in a reasonable period of time, consent should still be obtained.³⁷ The emergency personnel making the judgment to transport without consent are afforded immunity from suit for any liability arising from such lack of consent.³⁸

One exception to the above-noted rule is made for minors aged fourteen or older.³⁹ The law allows that consent of such a minor who is physically capable of giving the consent must be obtained prior to transport or treatment.⁴⁰

2. Medical Records

a. Release Authorization

A new law will lessen the practical burdens of obtaining medical record releases by patients.⁴¹ The new law will allow health care providers to treat as an original document any photocopy, facsimile reproduction, or other form of copy of a signed original

34. See VA. CODE ANN. § 54.1-2969 (Cum. Supp. 2000).

35. *Id.* § 54.1-2969(C) (Cum. Supp. 2000).

36. *Id.*

37. *Id.*

38. *Id.* § 54.1-2969(D) (Cum. Supp. 2000).

39. *Id.* § 54.1-2969(C) (Cum. Supp. 2000).

40. *Id.*

41. *Id.* § 8.01-413 (Repl. Vol. 2000).

consent to release of medical records.⁴² This law will reduce the burdens on patients attempting to obtain release of their own medical records, as well as ease the burden on providers by allowing more efficient means for transmission of consents to release of records by not always requiring that a signed original release be obtained.

b. Mental Health Records of Minors

The legislature carried over for consideration in the next legislative session a measure that would have allowed mental health care providers to refuse to release the records of a minor.⁴³ This proposed law would require that if the provider is of the opinion that the release of the records would not be in the best interest of the child's course of treatment, then the provider could refuse disclosure.⁴⁴ The bill did provide for a petition by a parent to the Juvenile and Domestic Relations District Court for access to the records.⁴⁵ In such an event, a guardian ad litem would be appointed on behalf of the minor and the court would be required to conduct an in camera review of the records to determine if nondisclosure was, in fact, in the best interest of the child.⁴⁶

c. Confidentiality of Records in Disease Investigation

The legislature also failed to take action on a bill regarding the protection of the confidentiality of medical records examined in the course of an investigation of a communicable disease.⁴⁷ The bill proposed amendments to Virginia Code section 32.1-41 regarding the preservation of anonymity of providers and patients involved in an investigation of a communicable disease by the Commissioner of Health.⁴⁸ The amendments would have prohibited the Commissioner from divulging the identity of any patients with noncommunicable diseases if pertinent to an investigation,

42. *Id.* § 8.01-413(B) (Repl. Vol. 2000).

43. H.B. 46, Va. Gen. Assembly (Reg. Sess. 2000).

44. *Id.*

45. *Id.*

46. *Id.*

47. H.B. 604, Va. Gen. Assembly (Reg. Sess. 2000).

48. *Id.*

research, or study unless the Commissioner had the written consent of the patient (or the patient's parent or guardian) or a court order allowing the disclosure.⁴⁹ The proposed law did allow the Commissioner to divulge (at his discretion) the identity of persons with communicable diseases and the practitioners involved with the investigation, study, or research.⁵⁰

3. Advance Directives

a. Inappropriate/Unethical Directives

The legislature passed a measure which requires physicians, who have determined that the wishes of a patient, as expressed in a written advance directive or through an appointed health care decision-maker (or proxy), are unethical or medically inappropriate, to make reasonable efforts to inform the patient or the patient's proxy of such a determination and the reasons for the determination.⁵¹ Furthermore, if the situation cannot be resolved, the physician is required to make reasonable efforts to transfer the patient to another physician who is willing to comply with the terms of the directive.⁵²

The objecting physician must allow a minimum of fourteen days for the transfer of the patient to the care of another physician who is willing to comply with the terms of the directive.⁵³ The transferring physician must continue to provide the patient with life-sustaining care that is reasonably available to the patient.⁵⁴ The physician is not, however, required to provide any treatment that he is not physically or legally capable of providing.⁵⁵ The law defines "life-sustaining care" as "any ongoing medical treatment that utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function, including hydration, nutrition, maintenance medication, and cardio-pulmonary resuscitation."⁵⁶

49. *Id.*

50. *Id.*

51. VA. CODE ANN. § 54.1-2990 (Cum. Supp. 2000).

52. *Id.* § 54.1-2990(A) (Cum. Supp. 2000).

53. *Id.*

54. *Id.* § 54.1-2990(B) (Cum. Supp. 2000).

55. *Id.*

56. *Id.*

b. Promotion of Awareness of Use of Advance Directives

The legislature also approved a joint resolution to encourage public education on the use of advance directives.⁵⁷ The legislative resolution, observing the benefits of advance directives, calls upon the Virginia Board of Medicine, the Medical Society of Virginia, the Virginia Health Care Association, the Virginia Hospital and Healthcare Association, and other professional health care associations to encourage their members to promote their awareness and use.⁵⁸ The legislature suggested that these associations achieve this goal by including such topics as end-of-life issues and advance directives in their continuing education programs, promote discussion of such issues in their treatment protocols, and collaborate to develop and implement procedures to allow effective transfer of advance directive documentation among health care practitioners and facilities.⁵⁹

The legislature also called upon the Virginia State Bar and the Virginia Bar Association to support these activities by preparing educational materials and offering assistance in these areas.⁶⁰

4. Health Maintenance Organization Liability

The Virginia legislature declined to follow the trend of a handful of other states in establishing a cause of action against health maintenance organizations ("HMOs") for liability for health care decisions.⁶¹ A proposed law would have established a requirement that a managed care health insurance plan be liable for the health care treatment decisions of the plan.⁶² The proposed law established a cause of action for damages resulting from an HMO's failure to exercise ordinary care in making a health care treatment decision.⁶³ The proposed law allowed for the filing of

57. See H.J. Res. 242, Va. Gen. Assembly (Reg. Sess. 2000).

58. *Id.*

59. *Id.*

60. *Id.*

61. A handful of states have passed laws which allow a patient to sue his HMO directly for injuries suffered as a result of health care decisions the HMO made. Managed Health Care Insurance Accountability Act of 1999, ch. 536, 1999 Cal. Adv. Legis. Serv. 536 (Deering); Act of Apr. 22, 1999, ch. 281, 1999 Ga. Laws 281; Act of May 22, 1997, ch. 163, 1997 Tex. Gen. Laws 163.

62. H.B. 92, Va. Gen. Assembly (Reg. Sess. 2000).

63. *Id.*

suit directly in lieu of using the utilization review grievance process of the health plan.⁶⁴

C. *Health Care Professions, Providers, and Facilities*

1. Certificate of Public Need for Health Care Facilities

a. Review Process for Certificate of Public Need

New legislation aimed at making the certificate of public need process more efficient and making other technical changes became law.⁶⁵ Among the changes made by the new law are: (1) changing the time frame for review of an application by the Commissioner from fifteen days to forty-five days;⁶⁶ (2) allowance for the application to be deemed approved if the Commissioner has not made a decision within seventy days of the closing of the record;⁶⁷ (3) elimination of the requirement that the Commissioner refund fifty percent of the application fee if a decision is not made within forty-five days;⁶⁸ and (4) allowing an applicant to petition for injunctive relief if the Commissioner has made no decision within forty-five days of the application.⁶⁹

b. Deregulation of Certificate of Public Need Process

The second piece of legislation dealing with the certificate of public need process calls for the phase-out of the process by July 1, 2004.⁷⁰ The law requires the Joint Commission on Health Care to establish a plan of deregulation.⁷¹ The plan must be submitted to the 2001 General Assembly and approved by that body.⁷²

The law requires that a deregulation plan include: (1) a plan to meet the health care needs of uninsured and indigent citizens; (2)

64. *Id.*

65. VA. CODE ANN. § 32.1-102.6 (Cum. Supp. 2000).

66. *Id.* § 32.1-102.6(E)(6) (Cum. Supp. 2000).

67. *Id.* § 32.1-102.6(E)(7) (Cum. Supp. 2000).

68. *Id.* § 32.1-102.6(E)(8) (Cum. Supp. 2000).

69. *Id.*

70. *Id.* § 32.1-102.13 (Cum. Supp. 2000).

71. *Id.* § 32.1-102.13(A) (Cum. Supp. 2000).

72. *Id.* § 32.1-102.13(B) (Cum. Supp. 2000).

a provision of adequate oversight of the various deregulated services to protect public health and safety and promote quality of health services provided by deregulated health facilities and projects; (3) a monitoring plan for assessing the effects of deregulation on the number and location of medical facilities and projects in the Commonwealth; (4) the recommendation of appropriate regulations for nursing homes, certified nursing facilities, intermediate care facilities, extended care facilities, long-term care facilities and new hospitals with respect to requirements for determination of need for such facilities; (5) a schedule of recommended and required statutory changes to effectuate the deregulation plan; and (6) an assessment of deregulation upon the unique role of academic medical centers.⁷³ The Commission is also charged with assessing the fiscal impact of this deregulation on the state's health care financing programs.⁷⁴

2. Practitioners' Scope of Practice

a. Physician Assistants

The scope of practice of physician assistants has been expanded by a new law that allows physicians to delegate to physician assistants the responsibility for conducting initial evaluation and ongoing treatment of patients in hospitals.⁷⁵ This provision includes evaluation and treatment in an emergency department of a hospital by a physician assistant.⁷⁶ In treating or evaluating a patient, the physician assistant is required to "report any acute or significant finding or change in a patient's clinical status to the supervising physician as soon as circumstances require."⁷⁷ The physician assistant is required to record any such findings in the patient's medical record.⁷⁸ The physician assistant must also transfer, to the supervising physician, the direct care of any patient in an emergency department who has a life-threatening injury or illness.⁷⁹

73. *Id.* § 32.1-102.13(C) (Cum. Supp. 2000).

74. *Id.*

75. *Id.* § 54.1-2952(A) (Cum. Supp. 2000).

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

The law also places requirements upon the supervising physician.⁸⁰ The supervising physician must review, prior to a patient's discharge, the services rendered by the physician assistant in the emergency department.⁸¹ When the physician assistant is practicing in an emergency department, the supervising physician must be present in the facility to supervise the physician assistant.⁸² A physician responsible for the care of the patient must sign a protocol agreeing to act as a supervising physician for the physician assistant practicing in the hospital.⁸³

b. Nurse Practitioners

Nurse practitioners' ability to prescribe drugs has been expanded by law.⁸⁴ The law now allows nurse practitioners, in a series of staggered effective dates from July 1, 2000 through July 1, 2003, to prescribe drugs that belong to Schedules III through VI.⁸⁵ Prior to this enactment, nurse practitioners were only permitted to prescribe Schedule VI drugs.⁸⁶

The law also eliminates certain regulations regarding the prescriptive authority of nurse practitioners and the responsibility of the Boards of Nursing and Medicine with regard to regulating this authority.⁸⁷ Instead, the law substitutes requirements for these Boards to develop joint regulations regarding the assessment and review of nurse practitioner competency to prescribe drugs.⁸⁸ The Boards of Medicine and Nursing are also required to "promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients."⁸⁹

The new law also requires the Joint Commission on Health Care to examine the effects of nurse practitioner prescriptive authority and report upon the impact of this authority with regard to patient care quality, provider relationships, third-party

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.* § 54.1-2952(B) (Cum. Supp. 2000).

84. *Id.* § 54.1-2957.01(A) (Cum. Supp. 2000).

85. *Id.* For information regarding the classifications of drugs by Schedule, see VA CODE ANN. §§ 54.1-3443 to -3456 (Repl. Vol. 1998 & Cum. Supp. 2000).

86. *Id.* § 54.1-2957.01(A) (Repl. Vol. 1998).

87. *Id.* § 54.1-2957.01(C) (Cum. Supp. 2000).

88. *Id.*

89. *Id.*

reimbursement, physician practices, and patient satisfaction.⁹⁰ The Joint Commission is required to file a preliminary report with committees of the House and Senate by July 1, 2003.⁹¹

c. Utilization Review Medical Directors

Virginia joined a growing number of states in passing a law requiring the medical director of a utilization review agency to be licensed as a physician in the state in which the utilization review agency is being licensed.⁹² The new law requires the medical director of a utilization review organization, which is itself licensed in Virginia, to be licensed in the Commonwealth as well.⁹³ In addition, the law clarifies existing definitions and licensing requirements for “physician advisors” and “peer of a treating health care provider” under the statutes governing utilization review activities in the Commonwealth.⁹⁴ These individuals are not required to be licensed by Virginia per se, but must be licensed either by Virginia or by the licensing authority of some other state or commonwealth of the United States.⁹⁵

d. Midwives

A proposed law to establish licensure and regulation of midwives and the practice of midwifery was carried over until the next legislative session.⁹⁶ In addition, the suggested law contained a number of unrelated technical amendments to various other laws.⁹⁷

The law defines “midwifery” as the “assessment and care of a pregnant woman and her newborn during pregnancy, labor, birth and the postpartum period outside of a hospital.”⁹⁸ The proposed law establishes licensing, training, and educational requirements

90. *Id.* § 54.1-2957.01 editor’s note (Cum. Supp. 2000).

91. *Id.*

92. *Id.* § 32.1-137.7 (Cum. Supp. 2000); *see also* HAW. REV. STAT. ANN. § 334B-2 (1999); MISS. CODE ANN. § 41-83-31 (1999).

93. *See* VA. CODE ANN. § 32.1-137.7 (Cum. Supp. 2000).

94. *Id.*

95. *Id.*

96. S.B. 657, Va. Gen. Assembly (Reg. Sess. 2000).

97. *Id.*

98. *Id.*

for midwives.⁹⁹ The law would place responsibility for the regulation of midwifery under the Board of Health Professions.¹⁰⁰ The Board would be responsible for promulgating regulations to enforce the provisions of the law.¹⁰¹

The law establishes particular requirements with regard to the practice of midwifery and informed consent.¹⁰² A midwife would be required to obtain written, informed consent from a patient.¹⁰³ The consent must demonstrate the patient's understanding of, and consent to, the care of a midwife.¹⁰⁴ The consent form is specifically required to show the background and training of the midwife, a description of the arrangement for physician support and assistance, the level of malpractice or liability insurance of the midwife, and a description of the patient's right to file (as well as the process for doing so) a complaint with the Board of Health Professions.¹⁰⁵

3. Duties to Report/Inform

a. Adult Protective Services

A new law requires that "each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to [Virginia Code section] 63.1-55.3 on such reporting procedures and the consequences for failing to make a required report."¹⁰⁶ Virginia Code section 63.1-55.3 requires health care professionals, practitioners, and employees whose duties include full or part-time care of adults to file these reports.¹⁰⁷

b. Mental Health Providers

A new law now requires mental health providers to advise any patient whom the provider believes may have been the victim of a

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. VA. CODE ANN. § 32.1-127(B)(10) (Cum. Supp. 2000).

107. *Id.* § 63.1-55.3 (Cum. Supp. 2000).

violation of standards of conduct by another mental health provider of the patient's right to make a complaint to the Department of Health Professions.¹⁰⁸ The mental health provider shall provide the patient with information on how to contact the Department to lodge a complaint, including the Department's toll-free telephone number for registering a complaint.¹⁰⁹

The suspecting mental health provider must also make a record of the reasonable suspicions in the patient's record and include a description of the alleged misconduct, including information as to the licensure of the suspected provider and the dates of treatment involved.¹¹⁰ The suspecting provider must also document his conversation with the patient during which the provider informs the patient of his rights as required by the law.¹¹¹

According to the requirements of the law, the mental health provider who has such suspicions and acts will be shielded from any civil or criminal liability unless the provider acted maliciously or in bad faith.¹¹² The failure to inform the patient of his rights as required under the law can subject the provider to a civil penalty of up to \$100.¹¹³

D. *Health Insurance*

1. Medical Assistance Services

A new law makes numerous adjustments to medical assistance service overpayment appeals and the periodic surveys of the Commissioner of Health to certify nursing facilities for reimbursement under federal programs (i.e., Medicare and Medicaid).¹¹⁴

The law establishes that the periodic survey determinations of the Commissioner of Health constitute case decisions under the Administrative Process Act¹¹⁵ and are thus subject to administra-

108. *Id.* § 54.1-2400.4(A) (Cum. Supp. 2000).

109. *Id.* § 54.1-2400.4(B) (Cum. Supp. 2000).

110. *Id.*

111. *Id.*

112. *Id.* § 54.1-2400.4(C) (Cum. Supp. 2000).

113. *Id.* § 54.1-2400.4(D) (Cum. Supp. 2000).

114. *Id.* § 32.1-126 (Cum. Supp. 2000).

115. *Id.* §§ 9-6.14:1 to -6.14:25 (Repl. Vol. 1998 & Cum. Supp. 2000).

tive appeal.¹¹⁶ In addition, the survey findings will also be subject to judicial review.¹¹⁷ The Commissioner of Health is to monitor the effects of these changes and report to the Joint Commission on Health Care regarding the types of survey deficiencies appealed, the reasons for the finding of deficiencies, any federal actions taken as a result of the finding of deficiencies, any effects on patient care, and the costs to the Commonwealth of the appeals of such deficiencies.¹¹⁸

The other section of this law deals with medical assistance service overpayment appeals.¹¹⁹ Such appeals under the Virginia Medicaid program are to be determined within 180 days of the appeal request.¹²⁰ Failure to make an initial determination within this timeframe results in a presumption that the decision is in favor of the provider.¹²¹ A hearing officer is to make a determination within 120 days and forward a recommendation to the Director of the Department of Medical Assistance Services.¹²² The Director then must adopt the recommendation within sixty days unless the decision would be an error of law or violate Department policy.¹²³ The Director must explain any rejection of the determination of the hearing officer.¹²⁴

No recovery of funds is allowed prior to the final decision, but interest on the disputed amount will accrue from the date of the final determination.¹²⁵ The burden of proof in such an appeal shall be placed upon the provider to show entitlement to the funds and, should he prevail, a provider may recover attorney's fees.¹²⁶

2. Health Insurance for Children

The Virginia Children's Medical Security Insurance Plan

116. *Id.* § 32.1-126(B) (Cum. Supp. 2000).

117. *Id.*

118. *Id.* § 32.1-126 editor's note (Cum. Supp. 2000).

119. *Id.* § 32.1-325.1 (Cum. Supp. 2000).

120. *Id.* § 32.1-325.1(A) (Cum. Supp. 2000).

121. *Id.*

122. *Id.* § 32.1-325.1(B) (Cum. Supp. 2000).

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.* § 32.1-325.1(C) (Cum. Supp. 2000).

("CMSIP") was revised and renamed by a new law as the Family Access to Medical Insurance Security ("FAMIS").¹²⁷ FAMIS provides medical insurance to individuals under the age of nineteen who meet the following criteria: (1) individual's family income is at or below 200% of the federal poverty level; (2) individual is not eligible for medical assistance services under title XIX of the Social Security Act, as amended; (3) individual is not covered by a group health plan or health insurance coverage; and (4) individual has been without health insurance for at least six months.¹²⁸ Participants in the FAMIS program who fall between 100% and 200% of the federal poverty level are required to participate on a limited cost-sharing basis.¹²⁹ There is no cost-sharing required for well-child and preventative health care services.¹³⁰

The law requires that the plan provide comprehensive benefits.¹³¹ These benefits include medical, dental, vision, mental health and substance abuse services, physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students.¹³² FAMIS participants with access to employer-sponsored health insurance may enroll in an employer-sponsored plan and receive supplemental insurance up to the level of benefits provided for FAMIS beneficiaries.¹³³ FAMIS will make premium payments to the employer-sponsored plan so long as the plan is determined to be cost-effective.¹³⁴

The FAMIS provisions will not become effective until approved by the federal Health Care Financing Administration.¹³⁵

3. Uniform Managed Care Referral Form

The legislature directed that a uniform form be developed for managed care referrals in a recently passed law.¹³⁶ The law directs the State Corporation Commission to develop a uniform re-

127. *See id.* § 32.1-351 (Cum. Supp. 2000).

128. *Id.* § 32.1-351(A) (Cum. Supp. 2000).

129. *Id.* § 32.1-351(B) (Cum. Supp. 2000).

130. *Id.*

131. *Id.* § 32.1-351(C) (Cum. Supp. 2000).

132. *Id.*

133. *Id.* § 32.1-351(D) (Cum. Supp. 2000).

134. *Id.*

135. *Id.* § 32.1-351 editor's note (Cum. Supp. 2000).

136. *Id.* § 38.2-3407.4:1 (Cum. Supp. 2000).

ferral form to be used by all managed care health insurance plans.¹³⁷ The form must incorporate only the data elements adopted by the Health Care Financing Administration for its Electronic Data Interchange standards.¹³⁸ The form is to be used by any managed care health insurance plan that requires its insureds or participants to obtain a referral in writing prior to receiving any consultation services.¹³⁹ A managed care plan may not require additional referral forms or require modification of the uniform referral form as a condition of coverage.¹⁴⁰

III. JUDICIAL DEVELOPMENTS

This section of the article reviews decisions of Virginia courts that touch upon important health law concepts. Several of these decisions do not directly turn on points of health law. But nonetheless, the holdings of these cases have significant effect upon a variety of aspects of health law. Among these rulings are decisions affecting the evidentiary rules governing health and medical records, the scope of workers' compensation and the rules governing the application of workers' compensation benefits, and the definition and proofs required with regard to certain medical-legal issues such as the insanity defense. The cases summarized here have been organized by court of decision.

A. *Decisions of the Supreme Court of Virginia*

1. *Fruiterman v. Waziri*¹⁴¹

The Supreme Court of Virginia declined to extend the immunity protections of the Virginia Birth-Related Neurological Injury Compensation Act¹⁴² to a professional corporation in *Fruiterman v. Waziri*.¹⁴³ The case involved a suit by parents of an infant who died from brain damage suffered during delivery.¹⁴⁴ Plaintiff al-

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. 259 Va. 540, 525 S.E.2d 552 (2000).

142. VA. CODE ANN. §§ 38.2-5000 to -5021 (Repl. Vol. 1999 & Cum. Supp. 2000).

143. *Fruiterman*, 259 Va. at 545, 525 S.E.2d at 554 (2000).

144. *Id.* at 542, 525 S.E.2d at 553.

leged medical malpractice and wrongful death and sued the individual physician and the professional corporation for which the plaintiff practiced.¹⁴⁵ The lower court sustained the demurrer of the individual physician, but denied that of the co-defendant professional corporation.¹⁴⁶ On appeal, the supreme court affirmed the decision of the lower court.¹⁴⁷

The Virginia Birth-Related Neurological Injury Compensation Act provides immunity to “participating physician” and “participating hospital” providers from civil actions for birth-related neurological injuries.¹⁴⁸ The court noted that the definitions of these two terms were specific and narrow and did not include the pro-

145. *Id.*

146. *Id.*

147. *Id.* at 545, 525 S.E.2d at 555.

148. VA. CODE ANN. §§ 38.2-5000 to -5021 (Repl. Vol. 1999 & Cum. Supp. 2000). As codified during *Fruiterman v. Waziri*, the Virginia Birth-Related Neurological Injury Compensation Act defines “participating physician” as

a physician licensed in Virginia to practice medicine, who practices obstetrics or performs obstetrical services either full or part time or, as authorized in the plan of operation, a licensed nurse-midwife who performs obstetrical services, either full or part time, within the scope of such licensure and who at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the physician agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the Board of Medicine whereby the physician agreed to submit to review by the Board of Medicine as required by subsection B of § 38.2-5004, and (iii) had paid the participating physician assessment pursuant to § 38.2-5020 for the period of time in which the birth-related neurological injury occurred.

Id. § 5001 (Repl. Vol. 1999). The Act defines a “participating hospital” as

a hospital licensed in Virginia which at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the hospital agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Department of Health whereby the hospital agreed to submit to review of its obstetrical service, as required by subsection C of § 38.2-5004, and (iii) had paid the participating hospital assessment pursuant to § 38.2-5020 for the period of time in which the birth-related neurological injury occurred. The term also includes employees of such hospitals, excluding physicians or nurse-midwives who are eligible to qualify as participating physicians, acting in the course of and in the scope of their employment.

Id.

fessional corporation employing a "participating physician."¹⁴⁹

Recently, the legislature acted to change the law in response to this decision by expanding the definition of the terms in the statute to include a professional corporation.¹⁵⁰

2. *Mercer v. Commonwealth*¹⁵¹

In *Mercer v. Commonwealth*, the Supreme Court of Virginia addressed the question of whether polysubstance dependence ("PSD") constitutes "mental illness" as that term is defined in the statute regarding civil commitment.¹⁵² In this case, the appellant was found not guilty by reason of insanity on charges of carjacking, grand larceny, maiming and robbery.¹⁵³ Subsequently, the appellant was committed to the custody of the Department of Mental Health, Mental Retardation and Substance Abuse Service for inpatient care.¹⁵⁴ At a hearing to determine whether the commitment should continue, two expert witnesses, while agreeing that appellant suffered from PSD, disagreed as to whether she was "mentally ill" as that term is defined under Virginia Code section 37.1-1.¹⁵⁵ The lower court held that PSD did fall within the definition of mental illness under Virginia Code section 37.1-1.¹⁵⁶ The supreme court affirmed this determination.¹⁵⁷

The supreme court noted in its decision that while the language of Virginia Code section 37.1-1 does not expressly address the issue of whether PSD qualifies as a mental illness for conditional release purposes, when read in conjunction with other applicable and related code provisions (such as Virginia Code sections 19.2-182.3 and 182.5), the implication is clear that PSD is a mental illness under the law.¹⁵⁸ The court reinforced the notion that the issue of whether an acquittee under the NGRI provision suffers a mental illness is a question of fact for the trial court to

149. *Fruiterman*, 259 Va. at 544, 525 S.E.2d at 554.

150. VA. CODE ANN. § 38.2-5001 (Cum. Supp. 2000).

151. 259 Va. 235, 523 S.E.2d 213 (2000).

152. *Id.* at 237, 523 S.E.2d at 214.

153. *Id.* at 238, 523 S.E.2d at 214.

154. *Id.*

155. *Id.* at 238-39, 523 S.E.2d at 214-15.

156. *Id.* at 239, 523 S.E.2d at 215.

157. *Id.* at 242, 523 S.E.2d at 217.

158. *Id.* at 241, 523 S.E.2d at 216.

be resolved by considering the testimony of mental health experts and the relevant provisions of the law.¹⁵⁹

3. *Gilmore v. Finn*¹⁶⁰

In *Gilmore v. Finn*, a key case concerning end-of-life health care and advance directives, the Supreme Court of Virginia ruled on the issue of whether the intervention of Governor Gilmore to halt the withdrawal of life-sustaining measures was reasonable so as to prevent the patient's family, which prevailed on the merits of the case, from recovering fees and sanctions.¹⁶¹

In 1995, Hugh Finn was injured in an automobile accident and left in a persistent vegetative state and required artificial nutrition and hydration.¹⁶² His wife decided to remove the artificial hydration and nutrition.¹⁶³ In the initial suit, brought by another family member in chancery to obtain an injunction against the removal of life-sustaining procedures, the trial court denied the injunction because the withdrawal was deemed medically appropriate and ethical.¹⁶⁴ The Governor initiated suit under Virginia Code sections 2.1-49 and 54.1-2986.¹⁶⁵ The Governor's contention was that withdrawal of the procedures would result in the death of Finn and constitute euthanasia in violation of the provisions of Virginia Code section 54.1-2990.¹⁶⁶ The trial court denied the

159. *Id.* at 242, 523 S.E.2d at 217.

160. 259 Va. 448, 527 S.E.2d 426 (2000).

161. *Id.* at 466-67, 527 S.E.2d at 436.

162. *Id.* at 453, 527 S.E.2d at 428.

163. *Id.*

164. *Id.* at 454, 527 S.E.2d at 428.

165. *Id.* at 457-58, 527 S.E.2d at 430-31. Virginia Code section 2.1-49 grants the Governor authority, by suit or other action, to act to protect the interests or legal rights of the Commonwealth or its citizens. VA. CODE ANN. § 2.1-49 (Repl. Vol. 1995). The law allows the Governor to institute suit on behalf of its citizens acting in capacity of *parens patriae* where the Governor believes that existing legal procedures fail to adequately protect the rights or interests of citizens. *Id.* The Governor also cited Virginia Code section 54.1-2986(E) which grants the court authority to enjoin any action not found by preponderance of the evidence to have been lawfully authorized. *Id.* § 54.1-2986(E) (Repl. Vol. 1998 & Cum. Supp. 2000).

166. *Finn*, 259 Va. at 458, 527 S.E.2d at 431. Virginia Code section 54.1-2990 states:

Nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate. However, in such a case, if the physician's determination is contrary to the terms of an advance directive of a qualified patient or the treatment decision of a person designated to make

Governor's request for an injunction and the supreme court denied an emergency appeal for review.¹⁶⁷

Subsequently, the life-sustaining procedures were removed and Finn died.¹⁶⁸ Michelle Finn, his wife, moved for attorney's fees, costs, and sanctions under Virginia Code section 8.01-271.1.¹⁶⁹ The trial court awarded \$13,124.20 in compensatory damages.¹⁷⁰ The Governor appealed and the supreme court accepted review of the matter.¹⁷¹ The supreme court then determined that while the Governor could not reasonably believe that Finn was not in a persistent vegetative state, he could reasonably believe that the provisions of Virginia Code section 54.1-2990 might be applicable to Finn, notwithstanding the provisions of Virginia Code section 54.1-2986.¹⁷² Thus, the Governor's argument was warranted in law and the trial court erred in awarding sanctions.¹⁷³

In deciding this case, the supreme court addressed the issue of the tension between the two above-noted sections regarding end-of-life care and withdrawal of life-sustaining procedures.¹⁷⁴ While ruling that the reasonableness of the Governor's action in advancing a legal theory regarding the application of Virginia Code section 54.1-2990 did not allow for the sanctions the trial court imposed for violation of Virginia Code section 8.01-271.1, the supreme court stated its opinion that the Governor's contention was ultimately incorrect even if it was not without merit.¹⁷⁵ In doing so, the supreme court rebuffed the Governor's contention that the

the decision under this article or a Durable Do Not Resuscitate Order, the physician shall make a reasonable effort to inform the patient or the patient's designated decision-maker of such determination and the reasons for the determination. If the conflict remains unresolved, the physician shall make a reasonable effort to transfer the patient to another physician.

...

Nothing in this article shall be construed to condone, authorize or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

VA. CODE ANN. § 54.1-2990 (Cum. Supp. 2000).

167. *Finn*, 259 Va. at 459-60, 527 S.E.2d at 432.

168. *Id.* at 460, 527 S.E.2d at 432.

169. *Id.*

170. *Id.* at 462, 527 S.E.2d at 433.

171. *Id.* at 463, 527 S.E.2d at 434-35.

172. *Id.* at 463-69, 527 S.E.2d at 433-37.

173. *Id.* at 468, 527 S.E.2d at 437.

174. *Id.* at 467, 527 S.E.2d at 436.

175. *Id.*

withdrawal of artificial hydration and nutrition measures would initiate the process of dying rather than merely permit the natural process of dying for a patient in a persistent vegetative state.¹⁷⁶ The former would of course constitute euthanasia under the statute while the latter would be an allowable termination of a life sustaining procedure.¹⁷⁷

4. *Smyth County Community Hospital v. Town of Marion*¹⁷⁸

In *Smyth County Community Hospital v. Town of Marion*, the Supreme Court of Virginia overturned a lower court ruling and found that a tax exemption for a hospital applied to a nursing home owned and operated by the hospital despite the fact that the nursing home maintained a separate license and separate reporting forms.¹⁷⁹

From 1993 through 1995, Smyth County and the Town of Marion levied tax assessments against the nursing home for real and personal property taxes.¹⁸⁰ In 1996, the hospital filed suit for declaratory judgment and relief from the assessments.¹⁸¹ The trial court found that the nursing home was not tax exempt under the aegis of the hospital's tax exemption under Virginia Code section 58.1-3606(A)(5).¹⁸²

On appeal, the supreme court reversed and remanded the case.¹⁸³ The supreme court stressed in its decision that, while tax exemptions should be narrowly construed, the record as a whole must be examined to establish whether or not the exemption applies.¹⁸⁴ In this case, the supreme court found that the nursing home was property of the hospital which immediately and directly promoted the charitable purpose of the hospital.¹⁸⁵ The supreme court, in reaching this conclusion, considered the following factors significant: (1) the hospital's articles of incorporation

176. *Id.*

177. See VA. CODE ANN. § 54.1-2990 (Cum. Supp. 2000).

178. 259 Va. 328, 527 S.E.2d 401 (2000).

179. *Id.* at 336-37, 527 S.E.2d at 405-06.

180. *Id.* at 331, 527 S.E.2d at 402.

181. *Id.*

182. *Id.*

183. *Id.* at 337, 527 S.E.2d at 405-06.

184. *Id.* at 333-34, 527 S.E.2d at 403-04.

185. *Id.* at 335, 527 S.E.2d at 404-05.

listed the maintenance of medical facilities of all descriptions, including those for "nursing services," among its purposes; (2) the hospital owned the nursing home and operated it as a wholly-owned subsidiary; (3) the nursing home was governed by the hospital board of directors; (4) all of the nursing home staff were employed by the hospital; (5) the nursing home and hospital were a single entity on a consolidated financial report; and (6) the nursing home utilized the hospital financial accounts for payment of expenses and revenue collection.¹⁸⁶ The supreme court also noted that the property will be tax exempt if it directly and immediately promotes the purposes of the hospital.¹⁸⁷ Based on these two factors—indicia of ownership and dominant purpose of the property—the court concluded that the nursing home was tax exempt as property of the hospital.¹⁸⁸

5. *Carter v. Chesterfield County Health Commission*¹⁸⁹

In *Carter v. Chesterfield County Health Commission*, the Supreme Court of Virginia affirmed a lower court holding that stated a county health commission was a municipal corporation and entitled to sovereign immunity.¹⁹⁰ The case involved a suit by the administrator of a deceased's estate alleging negligent acts by employees of the Health Commission in treating or failing to treat the decedent in the Health Commission's operation of a nursing home.¹⁹¹ The Health Commission had filed a special plea of sovereign immunity and the trial court dismissed the action against the Health Commission.¹⁹²

In reviewing the case, the supreme court found that the Commission was performing a governmental function, not a proprietary one, because the operation of the nursing home was an exercise of police power for the common good.¹⁹³

186. *Id.* at 331-34, 527 S.E.2d at 402-04.

187. *Id.* at 336, 527 S.E.2d at 405.

188. *Id.* at 337, 527 S.E.2d at 405-06.

189. 259 Va. 588, 527 S.E.2d 783 (2000).

190. *Id.* at 594, 527 S.E.2d at 787.

191. *Id.* at 590, 527 S.E.2d at 784.

192. *Id.*

193. *Id.* at 594, 527 S.E.2d at 787.

B. *Decisions from the Virginia Court of Appeals*

1. *Matthews v. Commonwealth*¹⁹⁴

In *Matthews v. Commonwealth*, the Virginia Court of Appeals ruled that a hospital patient does not have an expectation of privacy in a hospital emergency ward treatment room and, therefore, the police may enter the room without a warrant and without violating the Fourth Amendment protections against unlawful searches and seizures.¹⁹⁵ The appellant in the case was attempting to overturn his conviction for capital murder on the grounds that the police had obtained evidence against him illegally while he received treatment in the hospital emergency room.¹⁹⁶ The court of appeals distinguished this case from cases involving private hospital rooms (where a warrant is required).¹⁹⁷

2. *Smith v. Commonwealth*¹⁹⁸

At issue in *Smith v. Commonwealth* was the admission, over appellant's objection, of hospital records regarding appellant's blood alcohol content at the time the hospital admitted him.¹⁹⁹ Appellant had been in an automobile accident.²⁰⁰ The basis of the objection was that the records were unsubstantiated and thus hearsay.²⁰¹ In affirming the trial court ruling, the court of appeals applied the modern Shopbook rule analysis to the issue of the admissibility of the medical records.²⁰² This rule is a "business record" exception to the exclusion of hearsay evidence.²⁰³ The rule allows the admission of hospital records without need for authentication if the records are: (1) made and maintained in the ordinary course of business; (2) relied upon to treat and care for pa-

194. 30 Va. App. 412, 517 S.E.2d 263 (Ct. App. 1999).

195. *Id.* at 413, 517 S.E.2d at 263.

196. *Id.* at 414, 517 S.E.2d at 263.

197. *Id.* at 414, 517 S.E.2d at 264 (distinguishing *Morris v. Commonwealth*, 208 Va. 331, 157 S.E.2d 191 (1967)).

198. No. 2332-98-2, 2000 Va. App. LEXIS 151 (Ct. App. Feb. 29, 2000) (unpublished decision).

199. *Id.* at *2.

200. *Id.*

201. *Id.* at *4.

202. *Id.* at *4-7.

203. *Id.* at *4.

tients; and (3) verified by witnesses to have been made by authorized persons at or near the time of the event recorded.²⁰⁴

3. *Turpin v. Fairfax County School Board*²⁰⁵

In *Turpin v. Fairfax County School Board*, the Virginia Court of Appeals affirmed a ruling of the Workers' Compensation Commission.²⁰⁶ Therein, plaintiff Turpin argued she was entitled to select another physician after her treating doctor refused to treat her.²⁰⁷ The Workers' Compensation Commission denied Turpin's claim.²⁰⁸

The court of appeals held that the issue of whether a treating physician has released or abandoned a patient is determined by the express intent of the physician, which the trier of fact determines by clear and convincing evidence.²⁰⁹ In the instant case, the court of appeals found that the factual finding of the Commission was supported by such evidence and that there was no basis for reversing the Commission's finding.²¹⁰

C. *Decisions from the Lower Courts*

*Marks v. Bowers*²¹¹ is a significant circuit court decision worth noting. In that case, the Henrico County Circuit Court held that a plaintiff seeking damages for personal injuries cannot admit into evidence medical and health expenses which have been written off and not charged to the plaintiff.²¹² The circuit court further held that these expenses could not be included in the collateral source rule.²¹³ The circuit court reasoned that the reimbursement of a provider is not payment of medical expenses to the plaintiff

204. *Id.* at *5-6.

205. No. 2933-98-4, 1999 Va. App. LEXIS 614 (Ct. App. Nov. 2, 1999) (unpublished decision).

206. *Id.* at *2.

207. *Id.*

208. *Id.* at *3.

209. *Id.* at *6-7 (citing *Jensen Press v. Ale*, 336 S.E.2d 522, 524 (1985)).

210. *Id.* at *7.

211. 49 Va. Cir. 494 (Cir. Ct. 1999) (Henrico County).

212. *Id.* at 497.

213. *Id.*

so as to constitute a "collateral source" to the plaintiff.²¹⁴ Also, the circuit court stated that the plaintiff cannot introduce an amount for which she is not responsible to pay as an expense.²¹⁵

IV. ADMINISTRATIVE LAW DEVELOPMENTS

The Commonwealth's administrative agencies promulgated three key sets of final regulations during the past year: requirements for independent external review of health plan denials, managed care quality assurance regulations, and Medicaid hospice benefit regulations.

A. *Independent External Review of Health Claim Denials*

The State Corporation Commission Bureau of Insurance promulgated final regulations to carry out the provisions of Virginia's Independent External Review of Adverse Utilization Review Decisions Law.²¹⁶ The provisions of the regulation establish the process for appeals to the Bureau of Insurance to obtain an independent external review of a final adverse determination made by or on behalf of a managed care health insurance plan.²¹⁷ In order to be eligible for an appeal, such a decision of a managed care insurance plan, or a utilization review agent acting on behalf of a plan, must meet the following criteria: (1) the appeal must involve health care services which cost more than \$500; (2) the person who filed the appeal must be a covered person under the plan at the time of the disputed services; (3) the available internal appeals procedures must have been exhausted (with some exception for emergency situations); and (4) the appellant must have completed the appeal form and filed it with the Bureau of Insurance.²¹⁸ Services or items which are excluded from coverage under the plan pursuant to an evidence of coverage or other member materials are not subject to the appeal process.²¹⁹

The regulations outline two sets of procedures—one for stan-

214. *Id.*

215. *Id.* (citing *Sykes v. Brown*, 156 Va. 881, 159 S.E. 202 (1931)).

216. *See* VA. CODE ANN. §§ 38.2-5900 to -5905 (Cum. Supp. 2000).

217. 14 VA. ADMIN. CODE 5-215-50 (Cum. Supp. 2000).

218. *Id.*

219. *Id.*

dard appeals and one for expedited appeals.²²⁰ Expedited appeals are those appeals that involve emergency health care and, as a result, must be decided within a shorter time frame than is normally allowed for a standard appeal.²²¹ The regulations define "[e]mergency health care" as "health care items and medical services furnished or required to evaluate and treat an emergency medical condition."²²²

Once the Bureau of Insurance accepts an appeal for review, it is assigned to an impartial health entity for actual review and decision on the appeal.²²³ The Bureau of Insurance is required by the law to contract with impartial health entities to conduct the appeals process and make determinations regarding appeals.²²⁴ The regulation outlines the standards that these entities must meet in order to be considered for a contract as an impartial health entity.²²⁵ These standards require that the impartial health entity have: (1) a quality assurance mechanism in place to ensure appeals are timely and properly conducted; (2) a process for selecting qualified and impartial clinical peer reviewers to conduct reviews; (3) procedures to ensure confidentiality of records; (4) ensured that the entity has no affiliation with a health plan, health plan association or professional association of providers; and (5) a process to ensure for each specific review that the entity and reviewer do not have any conflict of interest arising from association with the appellant, treating provider, utilization review entity making the adverse determination or other involved party (i.e., facility where treatment is proposed).²²⁶

B. *Managed Care Plan Quality Assurance*

The General Assembly passed a law in 1998 establishing a quality assurance certification program for managed care health insurance programs.²²⁷ This past year, final regulations were promulgated to carry out the provisions of that law.

220. *Id.*

221. *Id.*

222. *Id.* at 5-215-30 (Cum. Supp. 2000).

223. *Id.* at 5-215-70 (Cum. Supp. 2000).

224. *Id.* at 5-215-60 (Cum. Supp. 2000).

225. *Id.* at 5-215-110 (Cum. Supp. 2000).

226. *Id.*

227. *See* VA. CODE ANN. §§ 32.1-137.1 to -137.6 (Cum. Supp. 1998).

The extensive regulations provide that all licensed managed care health insurance plans must obtain a quality assurance certification from the Department of Health.²²⁸ The plans must renew this certification biennially.²²⁹ The purpose of the certification is to ensure the quality of health care services delivered by these organizations. Accreditation by a national accrediting body may be used, in lieu of a comprehensive on-site examination by the Department of Health, to meet the certification requirements of the regulation.²³⁰

The regulation sets forth certification standards for managed care plans in a wide variety of areas. These areas include provider credentialing, complaint systems, enrollee education and communication, data management, medical records, continuity and coordination of care, and utilization review management among others.²³¹

C. *Hospice Benefits under Medicaid*

The Department of Medical Assistance Services published final regulations regarding hospice benefits under the state Medicaid program.²³² The stated purpose of the regulations is to align the coverage of hospice services under the state Medicaid program with the standards applied to hospice benefits under the federal Medicare program.²³³

Hospice services are a range of health care services for the use of individuals with terminal illnesses and their families. In order to qualify for hospice services, an individual must be terminally ill with a life expectancy of six months or less.²³⁴ The covered services range from physician and inpatient hospital care, to social work and counseling on issues of bereavement, diet, and spiritual matters related to end-of-life care and dying.²³⁵ The hos-

228. See 12 VA. ADMIN. CODE 5-408-10 to -370 (Cum. Supp. 2000).

229. *Id.* at 5-408-30 (Cum. Supp. 2000).

230. *Id.* at 5-408-50 (Cum. Supp. 2000).

231. 12 VA. ADMIN. CODE 5-408-160 (Cum. Supp. 2000).

232. State Plan for Medical Assistance Services Relating to Hospice Services, 16 Va. Regs. Reg. 706 (Dec. 6, 1999) (to be codified at 12 VA. ADMIN. CODE 30-50-270).

233. *Id.*

234. *Id.* at 707 (to be codified at 12 VA. ADMIN. CODE 30-50-270(c)(4)).

235. *Id.* at 706-07 (to be codified at 12 VA. ADMIN. CODE 30-50-270(c)).

pice must provide directly certain services designated as "core services."²³⁶ The core services include nursing care, social work, and the counseling services.²³⁷ The remaining services may either be provided directly by the hospice or contracted out to other providers.²³⁸

V. CONCLUSION

As evidenced by the breadth of topics discussed in this article, health law in Virginia continues to evolve in a rapid and dynamic fashion in all three major legal arenas and in a wide variety of areas of public policy and law which collectively comprise the field of "health law." While the bulk of changes in the Commonwealth's health law continue to come from the General Assembly, the courts and administrative agencies also contribute significantly to the evolution of health law in Virginia, as demonstrated by the key judicial decisions and regulatory enactments discussed above. Additionally, as demonstrated by the fact that key pieces of legislation, dealing with such important issues as confidentiality of medical records and abortion, were carried over to the next session, health law will continue to undergo significant changes affecting all segments of the Commonwealth's population in the coming year and beyond.

236. *Id.* at 706 (to be codified at 12 VA. ADMIN. CODE 30-50-270(c)).

237. *Id.*

238. *Id.*