VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM

PROGRAM GUIDELINES

APPROVED OCTOBER 14, 2008

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to change by the Board of Directors of the Virginia Birth-Related Neurological Injury Compensation Program and may be superseded by changes to the Virginia Birth-Related Neurological Injury Compensation Act by the Virginia General Assembly.

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

Purpose of the Program

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

Nature of the Program

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

With exceptions, the benefits of the Birth-Injury Program are limited to actual medically necessary and reasonable expenses of medical and hospital,

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

Financing of the Program

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

Governance and Operation

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

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

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

Program Is Payer of Last Resort

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

Primary Insurance

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

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

Medical Review

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

BENEFITS

Counseling

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

Personal Nursing and Assistive Care

A. The Program will pay for appropriate medically necessary and reasonable nursing care or assistive care as recommended in writing by the admitted claimant's primary care physician.

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

C. The Program utilizes nursing agencies when available. All nursing agencies utilized by the Program must provide to the Program copies of their employment policies regarding the criminal history records checks and sex offender searches

conducted on their employees. All nursing agencies utilized by the Program must provide a certification to the Program for each employee the agencies place for claimants' care which verifies that the named employee has not been convicted for any offense listed as a barrier crime pursuant to Virginia Code §§ 37.2-314, 37.2-416, or 37.2-506. No nursing agency shall be reimbursed for any hours worked by an agency employee for which such certification has not been provided to the Program. Signed and dated time sheets and monthly care summaries must be submitted with each request for reimbursement. If an agency is unable to provide care, the Executive Director is authorized to approve other arrangements.

D. If a nursing agency is not available, or the claimant's parent or legal guardian chooses to employ a relative or legal guardian of the claimant to provide prescribed nursing or attendant care authorized by claimant's primary care physician or appropriate treating specialist physician, the Program may reimburse the admitted claimant's parent or legal guardian for care providers who are employed by the claimant's family as independent contractors, or household employees, as the case may be, upon approval of the Executive Director. The Program will reimburse admitted claimant families for employment-related taxes such as FICA or unemployment tax, related to the hiring of an independent contractor, upon receipt of proper documentation of payment of these taxes. The parent or legal guardian of the claimant must provide a certification to the Program for each independent contractor, or household employee, the parent or legal guardian hires for a claimant's care which verifies that the named

independent contractor, or household employee, has not been convicted for any offense listed as a barrier crime pursuant to Virginia Code §§ 37.2-314, 37.2-416, or 37.2-506. No parent or legal guardian shall be reimbursed for any hours worked by an independent contractor for which such certification has not been provided to the Program. The parent or legal guardian of the claimant will pay any application fees associated with requesting these background checks of the Virginia State Police. Upon receipt of the certification and a receipt from the Virginia State Police, or an authenticated copy of the cancelled check, the Program will reimburse those application fees associated with the application of the independent contractor, or household employee, actually hired. Signed and dated time sheets, signed and dated receipts of payment, and monthly care summaries must be submitted with each request for reimbursement.

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

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

approval from the Program and a letter of medical necessity from the attending physician.

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

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

I. The Program may reimburse for medically necessary and reasonable nursing and attendant care that is provided by a relative or legal guardian of a claimant so long as that care is beyond the scope of child care duties and services normally and gratuitously provided by family members to uninjured children and so long as such care and reimbursement requests are in accordance with other applicable provisions and the following:

1. The relative or legal guardian providing the care must be at least 18 years of age.

2. The parent or legal guardian of the claimant must submit a letter of medical necessity from the claimant's primary care physician or appropriate treating specialist physician which sets forth the number of nursing or attendant care hours needed per day, the physician's assessment regarding the level of care required, and certification that the intended caregiver is appropriately trained, qualified and physically capable of performing the required home medical and attendant care duties. Medically necessary care to be provided by a relative or legal guardian of a claimant shall be performed only at the direction and control of the claimant's primary care physician or appropriate treating specialist physician.

3. The parent or legal guardian of the claimant must provide a certification to the Program for each caregiver the parent or legal guardian hires for a claimant's care which verifies that the named caregiver has not been convicted for any offense listed as a barrier crime pursuant to Virginia Code §§ 37.2-314, 37.2-416, or 37.2-506. No parent or legal guardian shall be reimbursed for any hours worked by a caregiver for which such certification has not been provided to the Program. The parent or legal guardian of the claimant will pay any application fees associated with requesting these background checks of the Virginia State Police. Upon receipt of the certification and a receipt from the Virginia State Police, or an authenticated copy of the

cancelled check, the Program will reimburse those application fees associated with the application of the caregiver actually hired.

4. Any relative or legal guardian of a claimant providing caregiver services must provide a signed release of liability form to the Program regarding any potential injury sustained during the course of providing services to the claimant.

5. Any parent or legal guardian of a claimant choosing to utilize nursing or attendant care that is provided by a relative or legal guardian in lieu of nursing or other professional caregiver services must provide a signed release of liability form to the Program regarding any potential injury sustained by claimant during the course of receiving care.

6. Signed and dated time sheets, signed and dated receipts of payment, and monthly care summaries must be submitted with each request for reimbursement.

7. The Program will not reimburse for care provided by a nurse or other professional caregiver and by a relative or legal guardian for the same hours. Hours of care provided by a relative or legal guardian of a claimant cannot be used to supplement hours of care provided by professional caregivers or nursing agencies to the extent that those

hours would exceed the total hours deemed medically necessary and authorized by the Program.

8. No more than 12 hours within a 24-hour period may be reimbursed for care provided by any single relative or legal guardian of a claimant.

9. The rate of reimbursement for nursing and attendant care that is provided by a relative or legal guardian of a claimant shall be the average hourly rate for a “Home Health Aide” (combined all industries) as reported by the Commonwealth of Virginia’s Labor Market Data report for the applicable Metropolitan Statistical Area in the most recently published data available. The Program will reimburse an admitted claimant’s parent or legal guardian for employment-related taxes, such as FICA or unemployment tax, resulting from that parent or legal guardian’s employment of a relative or legal guardian as the admitted claimant’s caregiver as set forth in these Guidelines, upon receipt of proper documentation of payment of these taxes.

10. The Program’s Executive Director and its staff reserve the right to have reviewed each nursing or attendant care plan and/or physician orders for medical necessity.

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

K. Travel expenses associated with nursing care are reimbursable only if the travel is medically necessary. No travel expenses will be paid for nurses or caregivers accompanying families on vacation or other non-medically necessary travel. Travel expenses for medically necessary nursing or attendant care during medically necessary travel will only be paid for one person in addition to the claimant. All such payments or reimbursements are made to the parent or guardian of the infant, not to the caregiver.

Dental Care

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

Therapy

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

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

Transportation - Vans

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

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

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

if an agreeable purchase price is agreed upon with the Executive Director of the Program.

D. All vans returned to the Program should be in good working order and be able to pass a Virginia state inspection. If the van is not in good working order or cannot pass a Virginia state inspection, claimant's parent or legal guardian must have the defects repaired at his or her own cost, if the expense is not covered by insurance, prior to returning the vehicle to the Program.

Equipment

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

B. All medically necessary equipment (except vans) purchased entirely by the Program remains the property of the Program. Depending upon the type of equipment and its condition, it is expected that equipment will be returned to the Program when no longer required by the child. The family may purchase the equipment if a purchase price is agreed upon with the Executive Director. If the

equipment is not purchased entirely by the Program it does not have to be returned to the Program

Augmentative Communication Technology

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

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

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

Privately Owned Housing Assistance:

The Board's statutory authority concerns awards for the medical needs of the admitted claimants it serves. However, if an admitted claimant has medically necessary housing needs that can be addressed in the non-rental home currently owned and occupied by the admitted claimant's family or guardian, the Board will provide one-time funding for medically necessary modification to, or construction of, an accessible bedroom and bathroom if such modification or construction is feasible and reasonable. This modification or construction must be within the Program's allowable standards for cost, space and other factors before funding for an accessible bedroom and bathroom will be authorized. The Program's construction manager or other qualified professional will determine the feasibility of these modifications or construction and whether the admitted claimant's needs will be met in the contemplated project.

Rental Housing Assistance

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

B. The handicapped accessible rental unit should meet all applicable regulations of the Americans With Disabilities Act. Exceptions to meeting the ADA regulations must be approved by the Program's Board of Directors. Prior to providing reimbursement the Program may require certification of the rental unit's suitability for the claimant and/or compliance with this policy.

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

Funeral Expenses

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

Attorneys' Fees

Virginia law authorizes payment of reasonable attorneys' fees incurred in the initial filing of a claim to enter the Program, subject to the approval and award of the Commission.

Miscellaneous Expenses

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

1. Mileage will be reimbursed at fifty (50%) percent of the U.S. Internal Revenue Service's mileage rate for vans provided by the Program. Mileage reimbursement typically covers gasoline and other costs of operation. Since the Program provides the van in this instance, the Program's mileage reimbursement is intended only to cover the cost of gasoline associated with medically necessary transportation. Mileage is based on the distance from the home to the appointment location. Verification may be required by the Program.

2. For use of personal vehicles, reimbursement will be at the U.S. Internal Revenue Service's mileage rate. In the event a van provided by the Program is unavailable, the mileage reimbursement allowance provided would be that allowed for vans purchased by the Program. Upon submission of receipts, the Program will reimburse other medically necessary transportation expenses not otherwise reimbursed.

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

C. Cell Phones: If the Program receives a prescription from the admitted claimant's primary care physician or appropriate treating specialist physician that a cellular telephone is medically necessary, the Program will pay for basic monthly emergency service. If basic *emergency service* is unavailable, the Program will pay for basic monthly service only. If installation of the cellular telephone is required, the phone must be installed in the vehicle in which the

admitted claimant is transported (Please contact the Program for the current allowable amounts).

D. Diapers: Beginning at age three, the Program will pay for diapers for an admitted claimant when deemed medically necessary pursuant to the Program's purchasing guidelines. If the parent or guardian of an admitted claimant does not have receipts for the period of time between the child's third birthday and the child's admission into the Program, the parent or guardian may submit the reimbursement request with the prescription and receive reimbursement based upon the Medicaid reimbursement rate.

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

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

Other Procedures

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

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

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

C. Claims For Reimbursement: Requests for reimbursement of expenses from medical providers, pharmacies, equipment providers, medically necessary

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

D. Requests For Authorization To Obtain Services Outside Your Insurance Plan's Covered Area Or Network: In the event it is medically necessary to take an admitted claimant outside the claimant's applicable insurance plan's covered service area or the primary insurance's provider network for evaluation, surgery, etc., it must be ascertained if the primary insurance plan will pay for benefits and if so, what amount it will pay. After this is determined, the Program must be contacted for authorization prior to seeking services or the Program may determine not to pay any balance remaining on the bill for these services.

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

E. Medically Necessary Travel More Than 100 Miles From Claimant's Primary Residence: In the event it is medically necessary to take an admitted claimant outside the local service area (more than 100 miles from the claimant's primary residence) for evaluation, surgery or other medically necessary care, it

must be ascertained prior to the travel if the travel related expenses will be reimbursed by the Program. If pre-authorization is not obtained, the Program may not pay for these travel related expenses.

F. Requests For Benefits Not Specifically Addressed In Guidelines: These Guidelines authorize the Executive Director to provide the benefits described without referral to the Board except in exceptional circumstances, and in the Executive Director's discretion. The Board, however, realizes that there may be programs, equipment, or other items, which may be of value to an admitted claimant that these Guidelines do not address. If the parents or guardians feel a benefit not described in the Guidelines would be of value to the admitted claimant (the Executive Director is not authorized to provide those benefits without Board approval), the parents or guardians should write the Board via the Executive Director, who will bring these requests to the Board at their next meeting.

Experimental Treatment and Therapy:

Experimental treatments or therapy not typically covered by health insurance, including, but not limited to, conductive education, may be covered up to a maximum of $6,000.00 per year, combined, with written prior authorization from the Executive Director. The Board of Directors recognizes that such therapies or treatments may be useful for some Program claimants and, therefore, grants this discretionary benefit on a case-by-case basis. Because this benefit is not provided expressly by the Virginia Birth-Related Neurological Injury Compensation Act, however, there is no guarantee of coverage for experimental

therapy or treatment. This completely discretionary benefit may be rescinded at any time; especially if such rescission is warranted by the Board of Directors' fiduciary obligations set forth in Virginia Code §38.2-5016(F). Upon such recission, benefits under this policy will terminate immediately and no claimant will have any further recourse or any basis for a claim for further benefits under this policy.

(Note: This provision replaces the Internal Administrative Guidance document regarding Conductive Education and Intensive Physical Therapy which was last revised by the Board of Directors on May 8, 2007.)

A written request for authorization must be submitted to the Program in accordance with the following process:

A. A letter of medical necessity from the claimant's physiatrist, neurologist, or other appropriate treating specialist physician, who also regularly treats other CP patients, must be received by the Program. A letter of medical necessity from a physical therapist is not acceptable.

B. The letter of medical necessity must be received in the Program's offices at least 60 days prior to the desired start of treatment.

C. Evidence as to whether the primary insurer(s) or other payers will cover any portion of the cost must be submitted with the request.

D. At the Program's discretion, all requests for experimental treatments or therapies may be reviewed for medical necessity by an objective qualified physician.

E. All other Program provisions regarding therapies, including the travel policy, are applicable to authorized experimental treatments or therapies. These include, but are not limited to:

1. Payment for travel, lodging, and meals on a per diem basis based on current Commonwealth of Virginia rates;

2. For travel other than by car/van, prior authorization must be obtained.

F. Written authorization from the Program must be obtained by the claimant prior to any payments or reimbursements being made by the Program.

G. Total combined costs for experimental treatments or therapies, related equipment, and travel expenses during any single calendar year may not exceed $6,000.00.

H. Following any experimental therapy treatment, a complete and thorough progress report, prepared by the treating facility, must be submitted to the Program within 60 days of completion of the therapy.

I. No further sessions/treatments will be authorized prior to the Program's receiving such progress reports. The receipt of the reports does not guarantee that further treatments will be authorized.

J. The Program may request an independent progress evaluation by a qualified physician prior to any reauthorization for subsequent treatments. If the claimant's insurance will not cover this evaluation, the Program will pay for the evaluation at usual and customary rates. If the Program pays for the evaluation, that cost will not be considered to be part of the cost of the treatment.

A local qualified provider of the experimental therapy or treatment requested should be utilized unless the Program grants an exception for a specific treatment provider.

K. For any therapy or treatment proposed, no more than 100 hours will be authorized upon initial request. Additional authorization may be provided only after the procedures in paragraph H, of the Experimental Therapy section of these Guidelines, have been followed.

L. Nursing, CNA, or other personal assistance will not be provided for extended experimental therapy sessions of more than two hours per day unless a letter of medical necessity is received by the Program from an appropriate treating specialist physician. That letter must state specifically that a nurse must be present due to specified health risks to the claimant.

In determining whether authorization will be granted for experimental therapy or treatment, the Program will consider, including but not limited to, the following:

3. The overall cost associated with the experimental treatment or therapy. The cost for one person to accompany the claimant, if stated to be medically necessary by the treating physician; the duration of the Program; the expected benefits to the claimant; and the availability of the experimental program in Virginia.

4. The report from the claimant's treating physician regarding the medical necessity for the claimant to participate in the experimental program.

5. Whether there is medically recognized proof of results that the experimental therapy or treatment has benefitted other patients in similar circumstances.

6. The expected frequency and duration of the experimental treatment or therapy requested.

7. The Program may require third party medical reviews to evaluate the potential success, safety, and/or results of the experimental treatment or therapy.

The Program encourages families to seek out clinical trials being conducted by accredited medical facilities, medical schools, or other highly regarded and medically accepted facilities or organizations to help establish the medical efficacy of experimental treatments or therapies.

G. Disagreements: Disagreements concerning whether a service or item of equipment should be paid for, or reimbursed by, the Program may arise. If Program staff and the Executive Director cannot make a determination regarding a request, or cannot resolve a disagreement, then the Executive Director has been authorized by the Board to place the claimant's request on the Agenda for the Board's consideration and determination at its next regular meeting. The parents or guardians, within 30 days of receiving the Program staff's or Executive Director's written denial of a claim, may submit a written explanation of the dispute, provide documentation supporting the request and demonstrating that procedures for the submission of claims pursuant to the Program's Guidelines

have been followed, and request that the Board make a determination regarding the claim at its next regular meeting. The parents or guardians of the claimant may attend a meeting of the Board to make a presentation and to provide documentation in support of their request(s) in addition to submitting their written materials to the Program. If a dispute is not resolved by the Board of Directors, a petition of appeal may be filed with the Clerk of the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond, Virginia 23220 within 30 days of receipt of written notification of the Board of Directors' decision.