House Bill 1095

By: Representatives Cheokas of the 138th, Fleming of the 121st, and Stephens of the 164th

A BILL TO BE ENTITLED

AN ACT

1 To establish the "Patient Compensation Act"; to amend Title 51 of the Official Code of
2 Georgia Annotated, relating to torts, so as to create an alternative to medical malpractice
3 litigation whereby patients are compensated for medical injuries; to provide for a short title;
4 to provide for legislative findings and intent; to provide for definitions; to establish the
5 Patient Compensation System and the Patient Compensation Board; to provide for
6 committees; to provide for the filing of and disposition of applications; to provide for review
7 by an administrative law judge; to provide for appellate review; to provide for payment of
8 administration expenses; to require an annual report; to provide for funding; to provide for
9 related matters; to provide for severability; to provide for an effective date and applicability;
10 to repeal conflicting laws; and for other purposes.

11 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

12 **SECTION 1.**

13 Effective January 1, 2016, the cause of action under Georgia law for medical malpractice
14 against a provider as defined in Code Section 51-13-2 is hereby repealed in its entirety.

15 **SECTION 2.**

16 Title 51 of the Official Code of Georgia Annotated, relating to torts, is amended by repealing
17 in its entirety Chapter 13, relating to recovery in medical malpractice actions, and enacting
18 a new Chapter 13 to read as follows:

19 "CHAPTER 13

20 51-13-1.

21 This chapter shall be known and may be cited as the 'Patient Compensation Act.'

22 51-13-2.
23 As used in this chapter, the term:
24 (1) 'Applicant' means a person who files an application under this chapter requesting the
25 investigation of an alleged occurrence of a medical injury.
26 (2) 'Application' means a request for investigation by the Patient Compensation System
27 of an alleged occurrence of a medical injury and does not constitute a written demand for
28 payment under any applicable state or federal law.
29 (3) 'Board' means the Patient Compensation Board as created in Code Section 51-13-4.
30 (4) 'Collateral source' means any payments made to the applicant, or made on his or her
31 behalf, by or pursuant to:
32 (A) The United States Social Security Act; any federal, state, or local income disability
33 act; or any other public programs providing medical expenses, disability payments, or
34 other similar benefits, except as prohibited by federal law.
35 (B) Any health, sickness, or income disability insurance; automobile accident
36 insurance that provides health benefits or income disability coverage; and any other
37 similar insurance benefits, except life insurance benefits available to the applicant,
38 whether purchased by the applicant or provided by others.
39 (C) Any contract or agreement of any group, organization, partnership, or corporation
40 to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health
41 care services.
42 (D) Any contractual or voluntary wage continuation plan provided by employers or by
43 any other system intended to provide wages during a period of disability.
44 (5) 'Committee' means, as the context requires, the Medical Review Committee or the
45 Compensation Committee.
46 (6) 'Compensation schedule' means a schedule of compensation for medical injuries.
47 (7) 'Department' means the Department of Community Health.
48 (8) 'Independent medical review panel,' or 'panel,' means a panel convened by the chief
49 medical officer to review each application.
50 (9) 'Medical injury' means a personal injury or wrongful death due to medical treatment,
51 including a missed diagnosis, where all the following criteria exist:
52 (A) The provider performed a medical treatment on the applicant;
53 (B) The applicant suffered a medical injury with damages;
54 (C) The medical treatment was the proximate cause of the damages; and
55 (D) Based on the facts at the time of medical treatment, one or more of the following:
56 (i) An accepted method of medical services was not used for treatment;
57 (ii) An accepted method of medical services was used for treatment, but executed in
58 a substandard fashion.

59 For purposes of this definition, 'medical injury' shall not include an injury or wrongful
60 death caused by a product defect in a drug, as defined in Code Section 26-3-2, or a
61 device, as defined in Code Section 26-3-2.
62 (10) 'Office' means, as the context requires, the Office of Compensation, the Office of
63 Medical Review, or the Office of Quality Improvement.
64 (11) 'Panelist' means a person who meets the definition of a provider under this chapter
65 and is selected to serve on an independent medical review panel.
66 (12) 'Patient Compensation System' means the organization created pursuant to Code
67 Section 51-13-4.
68 (13) 'Provider' means any physician licensed under Chapter 34 of Title 43.

69 51-13-3.
70 (a)(1) The General Assembly finds that the lack of legal representation, and thus
71 compensation, for the vast majority of patients with legitimate injuries is creating an
72 access to courts crisis.
73 (2) The General Assembly finds that seeking compensation through medical malpractice
74 litigation is a costly and protracted process, such that legal counsel may only afford to
75 finance a small number of legitimate claims.
76 (3) The General Assembly finds that, even for patients who are able to obtain legal
77 representation, the delay to obtain compensation is averaging approximately five years,
78 creating a significant hardship for patients and their caregivers who often need access to
79 immediate care and compensation, thus having a negative impact on patient safety.
80 (4) The General Assembly finds that, because of continued exposure to liability, an
81 overwhelming majority of physicians practice defensive medicine by ordering
82 unnecessary tests and procedures, driving up the cost of health care for individuals
83 covered by public and private health insurance coverage and exposing patients to
84 unnecessary clinical risks.
85 (5) The General Assembly finds that a significant percentage of physicians are
86 continuing to retire from practice as a result of the cost and risk of medical liability in this
87 state.
88 (6) The General Assembly finds that recruiting physicians to Georgia and ensuring that
89 existing Georgia physicians continue to practice in this state is an overwhelming public
90 necessity.
91 (b)(1) The General Assembly intends to create a new remedy whereby patients are fairly
92 and expeditiously compensated for avoidable medical injuries. This alternative, as
93 provided in this chapter, is intended to significantly reduce the practice of defensive
94 medicine, thereby reducing health care costs, increasing the number of physicians

95 practicing in this state, improving patient safety, and providing patients fair and timely
96 compensation without the expense and delay of the court system.
97 (2) The General Assembly intends that applications filed under this chapter shall not
98 constitute a claim for medical malpractice, and any action on such applications under this
99 chapter shall not constitute a judgment or adjudication for medical malpractice.
100 (c) The rights and remedies granted by this Act on account of a medical injury shall
101 exclude all other rights and remedies of the applicant, his or her personal representative,
102 parents, dependents, and the next of kin, at common law or as provided in general law of
103 this state, against any provider directly involved in providing the medical treatment from
104 which such injury or death occurred, arising out of or related to a medical negligence claim,
105 whether in tort or in contract, with respect to such injury resulting from medical treatment
106 provided on or after January 1, 2017. Notwithstanding any other law, the provisions of this
107 chapter shall apply exclusively to applications submitted under this chapter. An applicant
108 whose injury is excluded from coverage by definition under this chapter may file a claim
109 for recovery of damages in accordance with the provisions of applicable law.
110 (d) Nothing in this chapter shall be construed to prohibit a provider from providing an
111 apology or early offer of settlement in satisfaction of a medical injury. An individual who
112 accepts a settlement offer may not file an application under this chapter for the same
113 medical injury. In addition, if an application has been filed prior to the offer of settlement,
114 the acceptance of the settlement offer by the applicant shall result in the withdrawal of the
115 application.

116 51-13-4.
117 (a) The Patient Compensation System is created and shall be administratively housed
118 within the department. The Patient Compensation System is a separate budget entity that
119 shall be responsible for its administrative functions and shall not be subject to control,
120 supervision, or direction by the department in any manner. The Patient Compensation
121 System shall administer the provisions of this chapter. The Patient Compensation System
122 shall not be entitled to expend funds in excess of those generated by the contributions as
123 determined in Code Section 51-13-8.
124 (b) The Patient Compensation Board is established to govern the Patient Compensation
125 System.
126 (1) The board shall be composed of 11 members who shall represent the medical, legal,
127 patient, and business communities from diverse geographic areas throughout the state.
128 Members of the board shall be appointed as follows:
129 (A) Five of the members shall be appointed by, and serve at the pleasure of, the
130 Governor, two of whom shall be a licensed physician who actively practices in this

131 state, one of whom shall be an executive in the business community, one of whom shall
132 be a certified public accountant who actively practices in this state, and one of whom
133 shall be an attorney.
134 (B) Three of the members shall be appointed by, and serve at the pleasure of, the
135 Lieutenant Governor, one of whom shall be a licensed physician who actively practices
136 in this state and one of whom shall be a patient advocate.
137 (C) Three of the members shall be appointed by, and serve at the pleasure of, the
138 Speaker of the House of Representatives, one of whom shall be a licensed physician
139 who actively practices in this state and one of whom shall be a patient advocate.
140 (2) Each member shall be appointed for a 4-year term. For the purpose of providing
141 staggered terms, of the initial appointments, the five members appointed by the Governor
142 shall be appointed to 2-year terms and the remaining six members shall be appointed to
143 3-year terms. If a vacancy occurs on the board before the expiration of a term, the
144 original appointing authority shall appoint a successor to serve the unexpired portion of
145 the term.
146 (3) The board shall annually elect from its membership one member to serve as chair of
147 the board and one member to serve as vice chair.
148 (4) The first meeting of the board shall be held no later than August 1, 2016. Thereafter,
149 the board shall meet at least quarterly upon the call of the chair. A majority of the board
150 members constitutes a quorum. Meetings may be held by teleconference, web
151 conference, or other electronic means.
152 (5) Members of the board and the committees shall serve without compensation but may
153 be reimbursed for per diem and travel expenses for required attendance at board and
154 committee meetings as shall be set and approved by the Office of Planning and Budget
155 and in conformance with rates and allowances set for members of other state boards.
156 (6) The board shall have the following powers and duties:
157 (A) Ensuring the operation of the Patient Compensation System in accordance with
158 applicable federal and state laws and regulations.
159 (B) Entering into contracts as necessary to administer this chapter, including , but not
160 limited to, contracts with the Georgia Composite Medical Board to collect and remit the
161 contributions as determined in Code Section 51-13-8 if desired.
162 (C) Employing an executive director and other staff as are necessary to perform the
163 functions of the Patient Compensation System, except that the Governor shall appoint
164 the initial executive director.
165 (D) Approving the hiring of a chief compensation officer and chief medical officer, as
166 recommended by the executive director.

167 (E) Approving a schedule of compensation for medical injuries, as recommended by
168 the Compensation Committee.
169 (F) Approving medical review panelists as recommended by the Medical Review
170 Committee.
171 (G) Approving an annual budget.
172 (H) Annually approving provider contribution amounts.
173 (7) The executive director shall oversee the operation of the Patient Compensation
174 System in accordance with this chapter. The following staff shall report directly to and
175 serve at the pleasure of the executive director:
176 (A) The advocacy director shall ensure that each applicant is provided high quality
177 individual assistance throughout the process, from initial filing to disposition of the
178 application. The advocacy director shall assist each applicant in determining whether
179 to retain an attorney, which assistance shall include an explanation of possible fee
180 arrangements and the benefits and disadvantages of retaining an attorney. If the
181 applicant seeks to file an application without an attorney, the advocacy director shall
182 assist the applicant in filing the application. In addition, the advocacy director shall
183 regularly provide status reports to the applicant regarding his or her application.
184 (B) The chief compensation officer shall manage the Office of Compensation. The
185 chief compensation officer shall recommend to the Compensation Committee a
186 compensation schedule for each type of injury. The chief compensation officer may not
187 be a licensed physician or an attorney.
188 (C) The chief financial officer shall be responsible for overseeing the financial
189 operations of the Patient Compensation System, including the annual development of
190 a budget.
191 (D) The chief legal officer shall represent the Patient Compensation System in all
192 contested applications, oversee the operation of the Patient Compensation System to
193 ensure compliance with established procedures, and ensure adherence to all applicable
194 federal and state laws and regulations.
195 (E) The chief medical officer shall be a physician licensed under Chapter 34 of Title
196 43 who shall manage the Office of Medical Review. The chief medical officer shall
197 recommend to the Medical Review Committee a qualified list of panelists for
198 independent medical review panels. In addition, the chief medical officer shall convene
199 independent medical review panels as necessary to review applications.
200 (F) The chief quality officer shall manage the Office of Quality Improvement.
201 (c) The following offices are established within the Patient Compensation System:
202 (1) The chief medical officer shall manage the Office of Medical Review. The Office
203 of Medical Review shall evaluate and, as necessary, investigate all applications in

204 accordance with this chapter. For the purpose of an investigation of an application, the
205 office shall have the power to administer oaths, take depositions, issue subpoenas, compel
206 the attendance of witnesses and the production of papers, documents, and other evidence,
207 and obtain patient records pursuant to the applicant's release of protected health
208 information.
209 (2) The chief compensation officer shall manage the Office of Compensation. The office
210 shall allocate compensation for each application determined for award by a panel and an
211 administrative law judge in accordance with the compensation schedule. The office shall
212 also ensure that the compensation schedule does not exceed the funds generated by the
213 contributions as determined in Code Section 51-13-8.
214 (3) The chief quality officer shall manage the Office of Quality Improvement. The office
215 shall regularly review applications data to conduct root cause analyses in order to develop
216 and disseminate best practices based on such reviews. In addition, the office shall capture
217 and record safety-related data obtained during an investigation conducted by the Office
218 of Medical Review, including the cause of the medical injury, the contributing factors,
219 and any interventions that may have prevented the injury.
220 (d) The board shall create a Medical Review Committee and a Compensation Committee.
221 The board may create additional committees as necessary to assist in the performance of
222 its duties and responsibilities.
223 (1) Each committee shall be composed of three board members chosen by a majority
224 vote of the board.
225 (A) The Medical Review Committee shall be composed of two physician and a board
226 member who is not an attorney. The board shall designate one of the physician
227 committee members as chair of the committee.
228 (B) The Compensation Committee shall be composed of a certified public accountant
229 and two board members who are not physicians or attorneys. The certified public
230 accountant shall serve as chair of the committee.
231 (2) Members of each committee shall serve 2-year terms, within their respective terms
232 as board members. If a vacancy occurs on a committee, the board shall appoint a
233 successor to serve the unexpired portion of the term. A committee member who is
234 removed or resigns from the board shall be removed from the committee.
235 (3) The board shall annually designate a chair of each committee in accordance with this
236 subsection.
237 (4) Each committee shall meet at least quarterly or at the specific direction of the board.
238 Meetings may be held by teleconference, web conference, or other electronic means.

239 (5)(A) The Medical Review Committee shall, in consultation with the chief medical
240 officer, recommend to the board a comprehensive list of panelists who shall serve on
241 the independent medical review panels as needed.
242 (B) The Compensation Committee shall, in consultation with the chief compensation
243 officer, recommend to the board:
244 (i) A compensation schedule that shall not exceed the funds generated by the
245 contributions as determined in Code Section 51-13-8.
246 (ii) Guidelines for the payment of compensation awards through periodic payments.
247 (e) The chief medical officer shall convene an independent medical review panel to
248 evaluate whether an application constitutes a medical injury. Each panel shall be
249 composed of an odd number of at least three panelists chosen from a list of panelists
250 representing a like or similar specialty or practice as the providers rendering care as
251 described in the application and shall be convened upon the call of the chief medical
252 officer. Each panelist shall be paid a stipend as determined by the board for his or her
253 service on the panel. In order to expedite the review of applications, the chief medical
254 officer may, whenever practicable, group related applications together for consideration by
255 a single panel.
256 (f) A board member, panelist, or employee of the Patient Compensation System may not
257 engage in any conduct that constitutes a conflict of interest. For purposes of this
258 subsection, a 'conflict of interest' means a situation in which the private interest of a board
259 member, panelist, or employee could influence his or her judgment in the performance of
260 his or her duties under this chapter. A board member, panelist, or employee shall
261 immediately disclose in writing the presence of a conflict of interest when the board
262 member, panelist, or employee knows or should have known that the factual circumstances
263 surrounding a particular application constitutes or constituted a conflict of interest. A
264 board member, panelist, or employee who violates this subsection shall be subject to
265 disciplinary action as determined by the board. A conflict of interest includes, but is not
266 limited to:
267 (1) Any conduct that would lead a reasonable person having knowledge of all of the
268 circumstances to conclude that a panelist or employee is biased against or in favor of an
269 applicant.
270 (2) Participation in any application in which the board member, panelist, or employee,
271 or the parent, spouse, or child of a board member, panelist, or employee has a financial
272 interest.
273 (g) The board shall promulgate rules to administer the provisions of this chapter, which
274 shall include rules addressing:

275 (1) The application process, including forms necessary to collect relevant information
276 from applicants.
277 (2) Disciplinary procedures for a board member, panelist or employee who violates the
278 conflicts of interest provisions of this code section.
279 (3) Stipends paid to panelists for their service on an independent medical review panel,
280 which stipends may be scaled in accordance with the relative scarcity of the provider's
281 specialty, if applicable.
282 (4) Payment of compensation awards through periodic payments as recommended by the
283 Compensation Committee.

284 51-13-5.
285 (a) After the effective date of this Act, a person may continue to utilize medical
286 malpractice litigation or any other available remedy to obtain compensation for a medical
287 injury resulting from medical treatment provided prior to January 1, 2017. In order to
288 obtain compensation for a medical injury resulting from medical treatment provided on or
289 after January 1, 2017, a person, or his or her legal representative, shall file an application
290 with the Patient Compensation System. The application shall include the following:
291 (1) The name and address of the applicant or his or her representative and the basis of
292 the representation.
293 (2) The name and address of any provider who provided medical treatment allegedly
294 resulting in the medical injury.
295 (3) A brief statement of the facts and circumstances surrounding the personal injury or
296 wrongful death that gave rise to the application.
297 (4) An authorization for release to the Office of Medical Review all protected health
298 information that is potentially relevant to the application.
299 (5) Any other information that the applicant believes will be beneficial to the
300 investigatory process, including the names of potential witnesses.
301 (6) Documentation of any applicable private or governmental source of services or
302 reimbursement relative to the personal injury or wrongful death.
303 (b) If an application is not complete, the Patient Compensation System shall, within 30
304 days after the receipt of the initial application, notify the applicant in writing of any errors
305 or omissions. An applicant shall have 30 days in which to correct the errors or omissions
306 in the initial application.
307 (c) An application shall be filed within two years after the date on which a medical injury
308 occurred. In no event may an application be filed more than five years after the date on
309 which the medical treatment occurred. The foregoing are intended to create a two-year

310 statute of limitations and a five-year statute of ultimate repose and abrogation for
311 applications.
312 (d) After the filing of an application, the applicant may supplement the initial application
313 with additional information that the applicant believes may be beneficial in the resolution
314 of the application.
315 (e) Nothing in this chapter shall be construed to prohibit an applicant or provider from
316 retaining an attorney for the purpose of representing the applicant or provider in the review
317 and resolution of an application.

318 51-13-6.
319 (a) Individuals with relevant clinical expertise in the Office of Medical Review shall,
320 within 10 days of the receipt of a completed application, determine whether the application,
321 prima facie, constitutes a medical injury with damages.
322 (1) If the Office of Medical Review determines that the application, prima facie,
323 constitutes a medical injury with damages, the office shall immediately notify, by
324 registered or certified mail, each provider rendering care as described in the application.
325 The notification shall inform the provider that he or she may support the application to
326 expedite the processing of the application. A provider shall have 15 days from the receipt
327 of notification of an application to support the application. If the provider supports the
328 application, the Office of Medical Review shall review the application in accordance with
329 subsection (b) of this Code section.
330 (2) If the Office of Medical Review determines that the application does not, prima facie,
331 constitute a medical injury with damages, the office shall send a rejection letter to the
332 applicant by registered or certified mail, which shall inform the applicant of his or her
333 right of appeal.
334 (b) An application that is supported by a provider in accordance with subsection (a) of this
335 Code section shall be reviewed by individuals with relevant clinical expertise in the Office
336 of Medical Review within 30 days of the notification of the provider's support of the
337 application, to validate the application. If Office of Medical Review finds that the
338 application is valid, an administrative law judge, with input from the Office of
339 Compensation shall determine an award of compensation in accordance with subsection
340 (d) of this Code section. If the Office of Medical Review finds that the application is not
341 valid, the office shall immediately notify the applicant of the rejection of the application
342 and, in the case of fraud, the office shall immediately notify relevant law enforcement
343 authorities.
344 (c) If the Office of Medical Review determines that the application, prima facie,
345 constitutes a medical injury with damages, and the provider does not elect to support the

346 application, the office shall complete a thorough investigation of the application within 60
347 days after the determination by the office. The investigation shall be conducted by a team
348 with relevant clinical expertise and shall include a thorough investigation of all available
349 documentation, witnesses, and other information, including national practice standards for
350 the care and treatment of patients as determined to exist and be relevant by the chief
351 medical officer. Within 15 days after the completion of the investigation, the chief medical
352 officer shall allow the applicant and the provider to access records, statements, and other
353 information obtained in the course of its investigation, in accordance with relevant state
354 and federal laws. Within 30 days after the completion of the investigation, the chief
355 medical officer shall convene an independent medical review panel to determine whether
356 the application constitutes a medical injury. The independent medical review panel shall
357 have access to all redacted information obtained by the office in the course of its
358 investigation of the application, including national practice standards for the care and
359 treatment of patients as determined to exist and be relevant by the chief medical officer or
360 the panel itself. The independent medical review panel shall make a written determination
361 within 10 days after the convening of the panel, which written determination shall be
362 immediately provided to the applicant and the provider.
363 (1) The provider performed a medical treatment on the applicant;
364 (2) The applicant suffered a medical injury with damages;
365 (3) The medical treatment was the proximate cause of the damages; and
366 (4) Based on the facts at the time of medical treatment, one or more of the following:
367 (A) An accepted method of medical services was not used for treatment;
368 (B) An accepted method of medical services was used for treatment, but executed in
369 a substandard fashion.
370 (d)(1) If the independent medical review panel determines that the application constitutes
371 a medical injury, the Office of Medical Review shall immediately notify the provider by
372 registered or certified mail of the right to appeal the determination of the panel. The
373 provider shall have 15 days from the receipt of the letter in which to appeal the
374 determination of the panel pursuant to Code Section 51-13-7.
375 (2) If the independent medical review panel determines that the application does not
376 constitute a medical injury, the Office of Medical Review shall immediately notify the
377 applicant by registered or certified mail of the right to appeal the determination of the
378 panel. The applicant shall have 15 days from the receipt of the letter to appeal the
379 determination of the panel pursuant to Code Section 51-13-7.
380 (e) If an independent medical review panel finds that an application constitutes a medical
381 injury pursuant to subsection (c) of this Code section, and all appeals of that finding have
382 been exhausted pursuant to Code Section 51-13-7, an administrative law judge, with input

383 from the Office of Compensation shall, within 30 days after either the finding of the panel
384 or the exhaustion of all appeals of that finding, whichever occurs later, make a written
385 determination of an award of compensation in accordance with the compensation schedule
386 and the findings of the panel. The administrative law judge shall notify the applicant and
387 the provider by registered or certified mail of the amount of compensation, and shall
388 additionally explain to the applicant the process to appeal the determination. The applicant
389 shall have 15 days from the receipt of the letter to appeal the determination pursuant to
390 Code Section 51-13-7.
391 (f) Compensation for each application shall be offset by any past and future collateral
392 source payments. In addition, compensation may be paid by periodic payments as
393 determined by the Office of Compensation in accordance with the rules adopted by the
394 board.
395 (g) Within 15 days after either the acceptance of the determination of compensation by the
396 applicant or the conclusion of all appeals pursuant to Code Section 51-13-7, the Patient
397 Compensation System shall immediately provide compensation to the applicant in
398 accordance with the final compensation award. An applicant may petition the Superior
399 Court of Fulton County for enforcement of an award under this chapter.
400 (h) A provider who is the subject of an application under this chapter shall not be found
401 to have committed medical malpractice on the basis of the application and shall not be
402 reported to the Georgia Composite Medical Board or other relevant regulatory board as
403 appropriate.
404 (i) The Patient Compensation System shall provide the department and the Georgia
405 Composite Medical Board or other relevant regulatory board as appropriate with electronic
406 access to applications in which a medical injury was determined to exist where the provider
407 represents an imminent risk of harm to the public as determined by the chief medical
408 officer, in consultation with the independent medical review panel. The department and
409 the Georgia Composite Medical Board or other relevant regulatory board as appropriate
410 shall review such applications to determine whether any of the incidents that resulted in the
411 application potentially involved conduct by the licensee that is subject to disciplinary
412 action. Otherwise, Code Section 50-18-71 shall not apply to applications and any other
413 related documentation.

414 51-13-7.
415 (a) An administrative law judge shall make the written determination of award for
416 compensation and determine appeals filed by applicants pursuant to Code Section 51-13-6.
417 The administrative law judge shall exercise the full power and authority granted to him or
418 her, as necessary, to carry out the purposes of such section. The administrative law judge

419 shall determine whether the Office of Medical Review, the independent medical review
420 panel, or Office of Compensation, as appropriate, has faithfully followed the requirements
421 of this chapter and rules adopted hereunder in reviewing applications. If the administrative
422 law judge determines that such requirements were not followed in reviewing an
423 application, he or she shall require the chief medical officer to either reconvene the original
424 panel or convene a new panel, or require the Office of Compensation to redetermine the
425 compensation amount, in accordance with the determination of the administrative law
426 judge.
427 (b) A determination by an administrative law judge under this code section regarding the
428 faithful following of the requirements and rules under this chapter shall be conclusive and
429 binding as to all questions of fact. Such determination with findings of fact and
430 conclusions of law shall be sent to the applicant in question. An applicant may obtain
431 judicial review of such determination pursuant to Code Section 50-13-19.
432 (c) Upon a written petition by the applicant, an administrative law judge may grant, for
433 good cause, an extension of any of the time periods specified in this chapter. The relevant
434 time period shall be tolled from the date of the written petition until the date of the
435 determination by the administrative law judge.

436 51-13-8.
437 (a) The board shall annually determine a contribution that shall be paid by each provider
438 for the expense of the administration of this chapter and the compensation schedule as
439 determined by Code Section 51-13-4. The contribution amount shall be determined by
440 October 1 of each year, and shall be based on the anticipated expenses of the administration
441 of this chapter and the compensation schedule for the next calendar year. For the initial
442 year of 2017, the contribution rates shall be the maximum amounts for each provider as
443 allowed by this Code section.
444 (b) The contribution rate shall be $500.00 for all licensed providers not practicing in
445 Georgia. The contribution rate for providers practicing in Georgia shall be based on the
446 specialty practiced by the provider and shall not exceed the following amounts:
447 (1) The contribution rate for Category 1 providers shall not exceed $3,100 and includes:
448 Allergy, Dermatology (including minor surgery), Peer Review Only, Medical Director
449 Only (Non Managed Care Organization), Utilization Review Only, Medical Director
450 Only (Managed Care Organization), Forensic Medicine, Legal Medicine, Pathology
451 (including minor surgery), Psychiatry (including child), and Public Health.
452 (2) The contribution rate for Category 2 providers shall not exceed $3,500 and includes:
453 Addictionology, Aerospace Medicine, Diabetes (including minor surgery), Nutrition,
454 Pharmacology (clinical), and Utilization Management.

455 (3) The contribution rate for Category 3 providers shall not exceed $3,900 and includes:
456 Ambulatory Care (no surgery), Endocrinology (including minor surgery), Family/General
457 Practice (no surgery), General Preventive Medicine (no surgery), Geriatrics (including
458 minor surgery), Gynecology (including minor surgery), Hospitalist (no surgery), Internal
459 Medicine (no surgery), Neoplastic Diseases/Oncology (including minor surgery),
460 Nephrology (including minor surgery), Nuclear Medicine, Occupational Medicine,
461 Ophthalmology (no surgery), Otorhinolaryngology (no surgery), Pediatric (including
462 minor surgery), Physical Medicine and Rehabilitation, Physicians (including minor
463 surgery), Diagnostic Radiology (no surgery), and Rheumatology (no surgery).
464 (4) The contribution rate for Category 4 providers shall not exceed $5,100 and includes:
465 Cardiovascular Diseases (no surgery), Gastroenterology (including minor surgery),
466 Hematology (including minor surgery), Intensive Care Medicine, Ophthalmology
467 (surgery), Pulmonary Diseases (no surgery), and Radiation Therapy.
468 (5) The contribution rate for Category 5 providers shall not exceed $5,800 and includes:
469 Cardiovascular Diseases (minor surgery), Family/General Practice (minor surgery but no
470 obstetrics), Infectious Diseases (including minor surgery), Physicians (who perform any
471 of the following endoscopic retrograde cholangiopancreatography,
472 esophagogastroduodenoscopy, endoscopies other proctoscopies, pneumatic or mechanical
473 esophageal dialation, cystoscopies, colonoscopies, or sigmoidoscopies for examining
474 purposes only, Laproscopies [peritoneoscopies] except major surgery, radiopaque dye
475 injections into blood vessels, lymphatics sinus tracts or fistulate (not applicable to
476 radiology), Neonatology (minor surgery) and Neurology (including children and
477 including minor surgery).
478 (6) The contribution rate for Category 6 providers shall not exceed $6,200 and includes:
479 Internal Medicine (minor surgery).
480 (7) The contribution rate for Category 7 providers shall not exceed $6,800 and includes:
481 Gastroenterology (surgery), Physicians (who perform any arterial, cardiac or diagnostic
482 catheterization other than the occasional emergency insertion of pulmonary wedge
483 pressure recording catheters or temporary pacemakers, urethral catheterization or
484 umbilical cord catheterization for diagnostic purposes or for monitor the blood gases in
485 newborns receiving oxygen), Physicians (who perform Lasers used in therapy [but not
486 dermatology], radiation therapy [not applicable to radiology], shock therapy [not
487 applicable to psychiatry], angiography [not applicable to cardiology], arteriography [not
488 applicable to cardiology], phlebography, discography and myelography [not applicable
489 to neurology], pneumoencephalography, lymphangiography), Otorhinolaryngology
490 (minor surgery) and Urology (surgery).

491 (8) The contribution rate for Category 8 providers shall not exceed $6,500 and includes:
492 Anesthesiology.
493 (9) The contribution rate for Category 9 providers shall not exceed $7,700 and includes:
494 Family/General Practice (minor surgery including Obstetrics but no caesarian sections),
495 Physicians (assisting in surgery), Diagnostic Radiology (minor surgery), Radiology
496 (major invasive).
497 (10) The contribution rate for Category 10 providers shall not exceed $7,800 and
498 includes: Anesthesia (pain management including local, regional & epidural.
499 (11) The contribution rate for Category 11 providers shall not exceed $8,900 and
500 includes: Colon and/or Rectal surgery, Dermatology (surgery includes liposuction),
501 Emergency Medicine (no major surgery), Endocrinology (surgery), Geriatrics (surgery),
502 Neoplastic Diseases (surgery), Nephrology (surgery), Ophthalmology (ocular plastic),
503 Oral Maxillofacial Surgery, and Otorhinolaryngology (surgery and cosmetic).
504 (12) The contribution rate for Category 12 providers shall not exceed $10,600 and
505 includes: Endocrinology (reproductive), Family/General Practice (not primarily engaged
506 in surgery but includes abortions, obstetrics with caesarian sections and hysterectomies
507 combined not to exceed five per month and includes anesthesia, not to include 3 hours
508 per week), Physicians assisting in surgery and Podiatry.
509 (13) The contribution rate for Category 13 providers shall not exceed $12,500 and
510 includes: Plastic Surgery (no other classification).
511 (14) The contribution rate for Category 14 providers shall not exceed $13,200 and
512 includes: Abdominal Surgery, General Surgery (no other classification), Gynecological
513 Surgery, Hand and Foot Surgery, and Orthopedic Surgery (no spinal).
514 (15) The contribution rate for Category 15 providers shall not exceed $14,500 and
515 includes: Weight Reduction Surgery.
516 (16) The contribution rate for Category 16 providers shall not exceed $15,600 and
517 includes: Orthopedic Surgery.
518 (17) The contribution rate for Category 17 providers shall not exceed $17,500 and
519 includes: Cardiac Surgery, Neurological Surgery (limited to the back), Thoracic Surgery,
520 Traumatic Surgery, and Vascular Surgery.
521 (18) The contribution rate for Category 18 providers shall not exceed $19,500 and
522 includes: Obstetrics and gynecology surgery.
523 (19) The contribution rate for Category 19 providers shall not exceed $25,300 and
524 includes: Neurological Surgery (including children).
525 Notwithstanding the limitations above, the specialty component of the annual contribution
526 rate may be increased by the percentage change per year in the medical care component of
527 the consumer price index for all urban consumers.

528 (c) The contribution determined under this Code section shall be payable by each provider
529 by January 1 of each year. If any provider fails to pay the contribution determined under
530 this section, the board shall notify such provider by certified or registered mail that such
531 provider's license shall be subject to revocation if the contribution is not paid within 30
532 days from the date of the notice.
533 (d) A provider who fails to pay the contribution amount determined under this Code
534 section within 30 days from the date of the receipt of the notice shall have his or her license
535 revoked by the Georgia Composite Medical Board or other relevant regulatory board as
536 appropriate.
537 (e) All amounts collected under the provisions of this Code section shall be paid into the
538 state treasury and are intended to be used for the expenses of administration of this chapter
539 and the compensation schedule.

540 51-13-9.
541 The board shall annually submit, beginning on July 1, 2018, a report that describes the
542 filing and disposition of applications in the prior calendar year. The report shall include,
543 in the aggregate, the number of applications, the disposition of such applications, and
544 compensation awarded. The report shall also provide recommendations, if any, regarding
545 legislative changes that would improve the efficiency of the functions of the Patient
546 Compensation System. The report shall be provided to the Governor, the Lieutenant
547 Governor, and the Speaker of the House of Representatives."

548 **SECTION 3.**

549 In the event any section, subsection, sentence, clause, or phrase of this Act shall be declared
550 or adjudged invalid or unconstitutional, such adjudication shall in no manner affect the other
551 sections, subsections, sentences, clauses, or phrases of this Act, which shall remain of full
552 force and effect as if the section, subsection, sentence, clause, or phrase so declared or
553 adjudged invalid or unconstitutional were not originally a part hereof. The General
554 Assembly declares that it would have passed the remaining parts of this Act if it had known
555 that such part or parts hereof would be declared or adjudged invalid or unconstitutional.

556 **SECTION 4.**

557 (a) This Act shall become effective upon its approval by the Governor or upon its becoming
558 law without such approval.
559 (b) It is the intent of the General Assembly to apply the provisions of this Act to prior
560 medical injuries resulting from medical treatment provided on or after January 1, 2017.

561 **SECTION 5.**

562 All laws and parts of laws in conflict with this Act are repealed.