Senate Bill 86

By: Senators Beach of the 21st, Albers of the 56th, Gooch of the 51st, Hill of the 6th and Williams of the 19th

A BILL TO BE ENTITLED
AN ACT

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

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

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of action under Georgia law for medical malpractice against a provider as defined in Code Section 51-13-2 is hereby repealed in its entirety.

SECTION 2.

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

″CHAPTER 13

51-13-1.

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

51-13-2.

As used in this chapter, the term:

(1) 'Applicant' means a person who files an application under this chapter requesting the investigation of an alleged occurrence of a medical injury.

(2) 'Application' means a request for investigation by the Patient Compensation System of an alleged occurrence of a medical injury and does not constitute a written demand for payment under any applicable state or federal law.

(3) 'Board' means the Patient Compensation Board as created in Code Section 51-13-4.

(4) 'Collateral source' means any payments made to the applicant, or made on his or her behalf, by or pursuant to:

(A) The United States Social Security Act; any federal, state, or local income disability act; or any other public programs providing medical expenses, disability payments, or other similar benefits, except as prohibited by federal law.

(B) Any health, sickness, or income disability insurance; automobile accident insurance that provides health benefits or income disability coverage; and any other similar insurance benefits, except life insurance benefits available to the applicant, whether purchased by the applicant or provided by others.

(C) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services.

(D) Any contractual or voluntary wage continuation plan provided by employers or by any other system intended to provide wages during a period of disability.

(5) 'Committee' means, as the context requires, the Medical Review Committee or the Compensation Committee.

(6) 'Compensation schedule' means a schedule of compensation for medical injuries.

(7) 'Department' means the Department of Community Health.

(8) 'Independent medical review panel,' or 'panel,' means a panel convened by the chief medical officer to review each application.

(9) 'Medical injury' means a personal injury or wrongful death due to medical treatment, including a missed diagnosis, where all the following criteria exist:

(A) The provider performed a medical treatment on the applicant;

(B) The applicant suffered a medical injury with damages;

(C) The medical treatment was the proximate cause of the damages; and

(D) Based on the facts at the time of medical treatment, one or more of the following:

(i) An accepted method of medical services was not used for treatment;

(ii) An accepted method of medical services was used for treatment, but executed in a substandard fashion.

For purposes of this definition, 'medical injury' shall not include an injury or wrongful death caused by a product defect in a drug, as defined in Code Section 26-3-2, or a device, as defined in Code Section 26-3-2.

(10) 'Office' means, as the context requires, the Office of Compensation, the Office of Medical Review, or the Office of Quality Improvement.

(11) 'Panelist' means a person who meets the definition of a provider under this chapter and is selected to serve on an independent medical review panel.

(12) 'Patient Compensation System' means the organization created pursuant to Code Section 51-13-4.

(13) 'Provider' means any physician licensed under Chapter 34 of Title 43.

51-13-3.

(a)(1) The General Assembly finds that the lack of legal representation, and thus compensation, for the vast majority of patients with legitimate injuries is creating an access to courts crisis.

(2) The General Assembly finds that seeking compensation through medical malpractice litigation is a costly and protracted process, such that legal counsel may only afford to finance a small number of legitimate claims.

(3) The General Assembly finds that, even for patients who are able to obtain legal representation, the delay to obtain compensation is averaging approximately five years, creating a significant hardship for patients and their caregivers who often need access to immediate care and compensation, thus having a negative impact on patient safety.

(4) The General Assembly finds that, because of continued exposure to liability, an overwhelming majority of physicians practice defensive medicine by ordering unnecessary tests and procedures, driving up the cost of health care for individuals covered by public and private health insurance coverage and exposing patients to unnecessary clinical risks.

(5) The General Assembly finds that a significant percentage of physicians are continuing to retire from practice as a result of the cost and risk of medical liability in this state.

(6) The General Assembly finds that recruiting physicians to Georgia and ensuring that existing Georgia physicians continue to practice in this state is an overwhelming public necessity.

(b)(1) The General Assembly intends to create a new remedy whereby patients are fairly and expeditiously compensated for avoidable medical injuries. This alternative, as provided in this chapter, is intended to significantly reduce the practice of defensive medicine, thereby reducing health care costs, increasing the number of physicians

practicing in this state, improving patient safety, and providing patients fair and timely compensation without the expense and delay of the court system.

(2) The General Assembly intends that applications filed under this chapter shall not constitute a claim for medical malpractice, and any action on such applications under this chapter shall not constitute a judgment or adjudication for medical malpractice.

(c) The rights and remedies granted by this Act on account of a medical injury shall exclude all other rights and remedies of the applicant, his or her personal representative, parents, dependents, and the next of kin, at common law or as provided in general law of this state, against any provider directly involved in providing the medical treatment from which such injury or death occurred, arising out of or related to a medical negligence claim, whether in tort or in contract, with respect to such injury resulting from medical treatment provided on or after January 1, 2016. Notwithstanding any other law, the provisions of this chapter shall apply exclusively to applications submitted under this chapter. An applicant whose injury is excluded from coverage by definition under this chapter may file a claim for recovery of damages in accordance with the provisions of applicable law.

(d) Nothing in this chapter shall be construed to prohibit a provider from providing an apology or early offer of settlement in satisfaction of a medical injury. An individual who accepts a settlement offer may not file an application under this chapter for the same medical injury. In addition, if an application has been filed prior to the offer of settlement, the acceptance of the settlement offer by the applicant shall result in the withdrawal of the application.

51-13-4.

(a) The Patient Compensation System is created and shall be administratively housed within the department. The Patient Compensation System is a separate budget entity that shall be responsible for its administrative functions and shall not be subject to control, supervision, or direction by the department in any manner. The Patient Compensation System shall administer the provisions of this chapter. The Patient Compensation System shall not be entitled to expend funds in excess of those generated by the contributions as determined in Code Section 51-13-8.

(b) The Patient Compensation Board is established to govern the Patient Compensation System.

(1) The board shall be composed of 11 members who shall represent the medical, legal, patient, and business communities from diverse geographic areas throughout the state. Members of the board shall be appointed as follows:

(A) Five of the members shall be appointed by, and serve at the pleasure of, the Governor, two of whom shall be a licensed physician who actively practices in this

state, one of whom shall be an executive in the business community, one of whom shall be a certified public accountant who actively practices in this state, and one of whom shall be an attorney.

(B) Three of the members shall be appointed by, and serve at the pleasure of, the Lieutenant Governor, one of whom shall be a licensed physician who actively practices in this state and one of whom shall be a patient advocate.

(C) Three of the members shall be appointed by, and serve at the pleasure of, the Speaker of the House of Representatives, one of whom shall be a licensed physician who actively practices in this state and one of whom shall be a patient advocate.

(2) Each member shall be appointed for a 4-year term. For the purpose of providing staggered terms, of the initial appointments, the five members appointed by the Governor shall be appointed to 2-year terms and the remaining six members shall be appointed to 3-year terms. If a vacancy occurs on the board before the expiration of a term, the original appointing authority shall appoint a successor to serve the unexpired portion of the term.

(3) The board shall annually elect from its membership one member to serve as chair of the board and one member to serve as vice chair.

(4) The first meeting of the board shall be held no later than August 1, 2015. Thereafter, the board shall meet at least quarterly upon the call of the chair. A majority of the board members constitutes a quorum. Meetings may be held by teleconference, web conference, or other electronic means.

(5) Members of the board and the committees shall serve without compensation but may be reimbursed for per diem and travel expenses for required attendance at board and committee meetings as shall be set and approved by the Office of Planning and Budget and in conformance with rates and allowances set for members of other state boards.

(6) The board shall have the following powers and duties:

(A) Ensuring the operation of the Patient Compensation System in accordance with applicable federal and state laws and regulations.

(B) Entering into contracts as necessary to administer this chapter, including , but not limited to, contracts with the Georgia Composite Medical Board to collect and remit the contributions as determined in Code Section 51-13-8 if desired.

(C) Employing an executive director and other staff as are necessary to perform the functions of the Patient Compensation System, except that the Governor shall appoint the initial executive director.

(D) Approving the hiring of a chief compensation officer and chief medical officer, as recommended by the executive director.

(E) Approving a schedule of compensation for medical injuries, as recommended by the Compensation Committee.

(F) Approving medical review panelists as recommended by the Medical Review Committee.

(G) Approving an annual budget.

(H) Annually approving provider contribution amounts.

(7) The executive director shall oversee the operation of the Patient Compensation System in accordance with this chapter. The following staff shall report directly to and serve at the pleasure of the executive director:

(A) The advocacy director shall ensure that each applicant is provided high quality individual assistance throughout the process, from initial filing to disposition of the application. The advocacy director shall assist each applicant in determining whether to retain an attorney, which assistance shall include an explanation of possible fee arrangements and the benefits and disadvantages of retaining an attorney. If the applicant seeks to file an application without an attorney, the advocacy director shall assist the applicant in filing the application. In addition, the advocacy director shall regularly provide status reports to the applicant regarding his or her application.

(B) The chief compensation officer shall manage the Office of Compensation. The chief compensation officer shall recommend to the Compensation Committee a compensation schedule for each type of injury. The chief compensation officer may not be a licensed physician or an attorney.

(C) The chief financial officer shall be responsible for overseeing the financial operations of the Patient Compensation System, including the annual development of a budget.

(D) The chief legal officer shall represent the Patient Compensation System in all contested applications, oversee the operation of the Patient Compensation System to ensure compliance with established procedures, and ensure adherence to all applicable federal and state laws and regulations.

(E) The chief medical officer shall be a physician licensed under Chapter 34 of Title 43 who shall manage the Office of Medical Review. The chief medical officer shall recommend to the Medical Review Committee a qualified list of panelists for independent medical review panels. In addition, the chief medical officer shall convene independent medical review panels as necessary to review applications.

(F) The chief quality officer shall manage the Office of Quality Improvement.

(c) The following offices are established within the Patient Compensation System:

(1) The chief medical officer shall manage the Office of Medical Review. The Office of Medical Review shall evaluate and, as necessary, investigate all applications in

accordance with this chapter. For the purpose of an investigation of an application, the office shall have the power to administer oaths, take depositions, issue subpoenas, compel the attendance of witnesses and the production of papers, documents, and other evidence, and obtain patient records pursuant to the applicant's release of protected health information.

(2) The chief compensation officer shall manage the Office of Compensation. The office shall allocate compensation for each application determined for award by a panel in accordance with the compensation schedule. The office shall also ensure that the compensation schedule does not exceed the funds generated by the contributions as determined in Code Section 51-13-8.

(3) The chief quality officer shall manage the Office of Quality Improvement. The office shall regularly review applications data to conduct root cause analyses in order to develop and disseminate best practices based on such reviews. In addition, the office shall capture and record safety-related data obtained during an investigation conducted by the Office of Medical Review, including the cause of the medical injury, the contributing factors, and any interventions that may have prevented the injury.

(d) The board shall create a Medical Review Committee and a Compensation Committee. The board may create additional committees as necessary to assist in the performance of its duties and responsibilities.

(1) Each committee shall be composed of three board members chosen by a majority vote of the board.

(A) The Medical Review Committee shall be composed of two physician and a board member who is not an attorney. The board shall designate one of the physician committee members as chair of the committee.

(B) The Compensation Committee shall be composed of a certified public accountant and two board members who are not physicians or attorneys. The certified public accountant shall serve as chair of the committee.

(2) Members of each committee shall serve 2-year terms, within their respective terms as board members. If a vacancy occurs on a committee, the board shall appoint a successor to serve the unexpired portion of the term. A committee member who is removed or resigns from the board shall be removed from the committee.

(3) The board shall annually designate a chair of each committee in accordance with this subsection.

(4) Each committee shall meet at least quarterly or at the specific direction of the board. Meetings may be held by teleconference, web conference, or other electronic means.

(5)(A) The Medical Review Committee shall, in consultation with the chief medical officer, recommend to the board a comprehensive list of panelists who shall serve on the independent medical review panels as needed.

(B) The Compensation Committee shall, in consultation with the chief compensation officer, recommend to the board:

(i) A compensation schedule that shall not exceed the funds generated by the contributions as determined in Code Section 51-13-8.

(ii) Guidelines for the payment of compensation awards through periodic payments.

(e) The chief medical officer shall convene an independent medical review panel to evaluate whether an application constitutes a medical injury. Each panel shall be composed of an odd number of at least three panelists chosen from a list of panelists representing a like or similar specialty or practice as the providers rendering care as described in the application and shall be convened upon the call of the chief medical officer. Each panelist shall be paid a stipend as determined by the board for his or her service on the panel. In order to expedite the review of applications, the chief medical officer may, whenever practicable, group related applications together for consideration by a single panel.

(f) A board member, panelist, or employee of the Patient Compensation System may not engage in any conduct that constitutes a conflict of interest. For purposes of this subsection, a 'conflict of interest' means a situation in which the private interest of a board member, panelist, or employee could influence his or her judgment in the performance of his or her duties under this chapter. A board member, panelist, or employee shall immediately disclose in writing the presence of a conflict of interest when the board member, panelist, or employee knows or should have known that the factual circumstances surrounding a particular application constitutes or constituted a conflict of interest. A board member, panelist, or employee who violates this subsection shall be subject to disciplinary action as determined by the board. A conflict of interest includes, but is not limited to:

(1) Any conduct that would lead a reasonable person having knowledge of all of the circumstances to conclude that a panelist or employee is biased against or in favor of an applicant.

(2) Participation in any application in which the board member, panelist, or employee, or the parent, spouse, or child of a board member, panelist, or employee has a financial interest.

(g) The board shall promulgate rules to administer the provisions of this chapter, which shall include rules addressing:

(1) The application process, including forms necessary to collect relevant information from applicants.

(2) Disciplinary procedures for a board member, panelist or employee who violates the conflicts of interest provisions of this code section.

(3) Stipends paid to panelists for their service on an independent medical review panel, which stipends may be scaled in accordance with the relative scarcity of the provider's specialty, if applicable.

(4) Payment of compensation awards through periodic payments as recommended by the Compensation Committee.

51-13-5.

(a) After the effective date of this Act, a person may continue to utilize medical malpractice litigation or any other available remedy to obtain compensation for a medical injury resulting from medical treatment provided prior to January 1, 2016. In order to obtain compensation for a medical injury resulting from medical treatment provided on or after January 1, 2016, a person, or his or her legal representative, shall file an application with the Patient Compensation System. The application shall include the following:

(1) The name and address of the applicant or his or her representative and the basis of the representation.

(2) The name and address of any provider who provided medical treatment allegedly resulting in the medical injury.

(3) A brief statement of the facts and circumstances surrounding the personal injury or wrongful death that gave rise to the application.

(4) An authorization for release to the Office of Medical Review all protected health information that is potentially relevant to the application.

(5) Any other information that the applicant believes will be beneficial to the investigatory process, including the names of potential witnesses.

(6) Documentation of any applicable private or governmental source of services or reimbursement relative to the personal injury or wrongful death.

(b) If an application is not complete, the Patient Compensation System shall, within 30 days after the receipt of the initial application, notify the applicant in writing of any errors or omissions. An applicant shall have 30 days in which to correct the errors or omissions in the initial application.

(c) An application shall be filed within two years after the date on which a medical injury occurred. In no event may an application be filed more than five years after the date on which the medical treatment occurred. The foregoing are intended to create a two-year

statute of limitations and a five-year statute of ultimate repose and abrogation for applications.

(d) After the filing of an application, the applicant may supplement the initial application with additional information that the applicant believes may be beneficial in the resolution of the application.

(e) Nothing in this chapter shall be construed to prohibit an applicant or provider from retaining an attorney for the purpose of representing the applicant or provider in the review and resolution of an application.

51-13-6.

(a) Individuals with relevant clinical expertise in the Office of Medical Review shall, within 10 days of the receipt of a completed application, determine whether the application, prima facie, constitutes a medical injury with damages.

(1) If the Office of Medical Review determines that the application, prima facie, constitutes a medical injury with damages, the office shall immediately notify, by registered or certified mail, each provider rendering care as described in the application. The notification shall inform the provider that he or she may support the application to expedite the processing of the application. A provider shall have 15 days from the receipt of notification of an application to support the application. If the provider supports the application, the Office of Medical Review shall review the application in accordance with subsection (b) of this Code section.

(2) If the Office of Medical Review determines that the application does not, prima facie, constitute a medical injury with damages, the office shall send a rejection letter to the applicant by registered or certified mail, which shall inform the applicant of his or her right of appeal.

(b) An application that is supported by a provider in accordance with subsection (a) of this Code section shall be reviewed by individuals with relevant clinical expertise in the Office of Medical Review within 30 days of the notification of the provider's support of the application, to validate the application. If Office of Medical Review finds that the application is valid, the Office of Compensation shall determine an award of compensation in accordance with subsection (d) of this Code section. If the Office of Medical Review finds that the application is not valid, the office shall immediately notify the applicant of the rejection of the application and, in the case of fraud, the office shall immediately notify relevant law enforcement authorities.

(c) If the Office of Medical Review determines that the application, prima facie, constitutes a medical injury with damages, and the provider does not elect to support the application, the office shall complete a thorough investigation of the application within 60

days after the determination by the office. The investigation shall be conducted by a team with relevant clinical expertise and shall include a thorough investigation of all available documentation, witnesses, and other information, including national practice standards for the care and treatment of patients as determined to exist and be relevant by the chief medical officer. Within 15 days after the completion of the investigation, the chief medical officer shall allow the applicant and the provider to access records, statements, and other information obtained in the course of its investigation, in accordance with relevant state and federal laws. Within 30 days after the completion of the investigation, the chief medical officer shall convene an independent medical review panel to determine whether the application constitutes a medical injury. The independent medical review panel shall have access to all redacted information obtained by the office in the course of its investigation of the application, including national practice standards for the care and treatment of patients as determined to exist and be relevant by the chief medical officer or the panel itself. The independent medical review panel shall make a written determination within 10 days after the convening of the panel, which written determination shall be immediately provided to the applicant and the provider.

(1) The provider performed a medical treatment on the applicant;

(2) The applicant suffered a medical injury with damages;

(3) The medical treatment was the proximate cause of the damages; and

(4) Based on the facts at the time of medical treatment, one or more of the following:

(A) An accepted method of medical services was not used for treatment;

(B) An accepted method of medical services was used for treatment, but executed in a substandard fashion.

(d)(1) If the independent medical review panel determines that the application constitutes a medical injury, the Office of Medical Review shall immediately notify the provider by registered or certified mail of the right to appeal the determination of the panel. The provider shall have 15 days from the receipt of the letter in which to appeal the determination of the panel pursuant to Code Section 51-13-7.

(2) If the independent medical review panel determines that the application does not constitute a medical injury, the Office of Medical Review shall immediately notify the applicant by registered or certified mail of the right to appeal the determination of the panel. The applicant shall have 15 days from the receipt of the letter to appeal the determination of the panel pursuant to Code Section 51-13-7.

(e) If an independent medical review panel finds that an application constitutes a medical injury pursuant to subsection (c) of this Code section, and all appeals of that finding have been exhausted by the provider pursuant to Code Section 51-13-7, the Office of Compensation shall, within 30 days after either the finding of the panel or the exhaustion

of all appeals of that finding, whichever occurs later, make a written determination of an award of compensation in accordance with the compensation schedule and the findings of the panel. The office shall notify the applicant and the provider by registered or certified mail of the amount of compensation, and shall additionally explain to the applicant the process to appeal the determination of the office. The applicant shall have 15 days from the receipt of the letter to appeal the determination of the office pursuant to Code Section 51-13-7.

(f) Compensation for each application shall be offset by any past and future collateral source payments. In addition, compensation may be paid by periodic payments as determined by the Office of Compensation in accordance with the rules adopted by the board.

(g) Within 15 days after either the acceptance of the determination of compensation by the applicant or the conclusion of all appeals pursuant to Code Section 51-13-7, the Patient Compensation System shall immediately provide compensation to the applicant in accordance with the final compensation award. An applicant may petition the Superior Court of Fulton County for enforcement of an award under this chapter.

(h) A provider who is the subject of an application under this chapter shall not be found to have committed medical malpractice on the basis of the application and shall not be reported to the Georgia Composite Medical Board or other relevant regulatory board as appropriate.

(i) The Patient Compensation System shall provide the department and the Georgia Composite Medical Board or other relevant regulatory board as appropriate with electronic access to applications in which a medical injury was determined to exist where the provider represents an imminent risk of harm to the public as determined by the chief medical officer, in consultation with the independent medical review panel. The department and the Georgia Composite Medical Board or other relevant regulatory board as appropriate shall review such applications to determine whether any of the incidents that resulted in the application potentially involved conduct by the licensee that is subject to disciplinary action. Otherwise, Code Section 50-18-71 shall not apply to applications and any other related documentation.

51-13-7.

(a) An administrative law judge shall hear and determine appeals filed by applicants pursuant to Code Section 51-13-6 and shall exercise the full power and authority granted to him or her, as necessary, to carry out the purposes of such section. The administrative law judge shall be limited in his or her review to determining whether the Office of Medical Review, the independent medical review panel, or Office of Compensation, as

appropriate, has faithfully followed the requirements of this chapter and rules adopted hereunder in reviewing applications. If the administrative law judge determines that such requirements were not followed in reviewing an application, he or she shall require the chief medical officer to either reconvene the original panel or convene a new panel, or require the Office of Compensation to redetermine the compensation amount, in accordance with the determination of the administrative law judge.

(b) A determination by an administrative law judge under this code section regarding the faithful following of the requirements and rules under this chapter shall be conclusive and binding as to all questions of fact. Such determination with findings of fact and conclusions of law shall be sent to the applicant in question. An applicant may obtain judicial review of such determination pursuant to Code Section 50-13-19.

(c) Upon a written petition by the applicant, an administrative law judge may grant, for good cause, an extension of any of the time periods specified in this chapter. The relevant time period shall be tolled from the date of the written petition until the date of the determination by the administrative law judge.

51-13-8.

(a) The board shall annually determine a contribution that shall be paid by each provider for the expense of the administration of this chapter and the compensation schedule as determined by Code Section 51-13-4. The contribution amount shall be determined by October 1 of each year, and shall be based on the anticipated expenses of the administration of this chapter and the compensation schedule for the next calendar year. For the initial year of 2016, the contribution rates shall be the maximum amounts for each provider as allowed by this Code section.

(b) The contribution rate shall be $500.00 for all licensed providers not practicing in Georgia. The contribution rate for providers practicing in Georgia shall be based on the specialty practiced by the provider and shall not exceed the following amounts:

(1) The contribution rate for Category 1 providers shall not exceed $3,100 and includes: Allergy, Dermatology (including minor surgery), Peer Review Only, Medical Director Only (Non Managed Care Organization), Utilization Review Only, Medical Director Only (Managed Care Organization), Forensic Medicine, Legal Medicine, Pathology (including minor surgery), Psychiatry (including child), and Public Health.

(2) The contribution rate for Category 2 providers shall not exceed $3,500 and includes: Addictionology, Aerospace Medicine, Diabetes (including minor surgery), Nutrition, Pharmacology (clinical), and Utilization Management.

(3) The contribution rate for Category 3 providers shall not exceed $3,900 and includes: Ambulatory Care (no surgery), Endocrinology (including minor surgery), Family/General

Practice (no surgery), General Preventive Medicine (no surgery), Geriatrics (including minor surgery), Gynecology (including minor surgery), Hospitalist (no surgery), Internal Medicine (no surgery), Neoplastic Diseases/Oncology (including minor surgery), Nephrology (including minor surgery), Nuclear Medicine, Occupational Medicine, Ophthalmology (no surgery), Otorhinolaryngology (no surgery), Pediatric (including minor surgery), Physical Medicine and Rehabilitation, Physicians (including minor surgery), Diagnostic Radiology (no surgery), and Rheumatology (no surgery).

(4) The contribution rate for Category 4 providers shall not exceed $5,100 and includes: Cardiovascular Diseases (no surgery), Gastroenterology (including minor surgery), Hematology (including minor surgery), Intensive Care Medicine, Ophthalmology (surgery), Pulmonary Diseases (no surgery), and Radiation Therapy.

(5) The contribution rate for Category 5 providers shall not exceed $5,800 and includes: Cardiovascular Diseases (minor surgery), Family/General Practice (minor surgery but no obstetrics), Infectious Diseases (including minor surgery), Physicians (who perform any of the following endoscopic retrograde cholangiopancreatography, esophagogastroduodenoscopy, endoscopies other proctoscopies, pneumatic or mechanical esophageal dialation, cystoscopies, colonoscopies, or sigmoidoscopies for examining purposes only, Laproscopies [peritoneoscopies] except major surgery, radiopaque dye injections into blood vessels, lymphatics sinus tracts or fistulate (not applicable to radiology), Neonatology (minor surgery) and Neurology (including children and including minor surgery).

(6) The contribution rate for Category 6 providers shall not exceed $6,200 and includes: Internal Medicine (minor surgery).

(7) The contribution rate for Category 7 providers shall not exceed $6,800 and includes: Gastroenterology (surgery), Physicians (who perform any arterial, cardiac or diagnostic catheterization other than the occasional emergency insertion of pulmonary wedge pressure recording catheters or temporary pacemakers, urethral catheterization or umbilical cord catheterization for diagnostic purposes or for monitor the blood gases in newborns receiving oxygen), Physicians (who perform Lasers used in therapy [but not dermatology], radiation therapy [not applicable to radiology], shock therapy [not applicable to psychiatry], angiography [not applicable to cardiology], arteriography [not applicable to cardiology], phlebography, discography and myelography [not applicable to neurology], pneumoencephalography, lymphangiography), Otorhinolaryngology (minor surgery) and Urology (surgery).

(8) The contribution rate for Category 8 providers shall not exceed $6,500 and includes: Anesthesiology.

(9) The contribution rate for Category 9 providers shall not exceed $7,700 and includes: Family/General Practice (minor surgery including Obstetrics but no caesarian sections), Physicians (assisting in surgery), Diagnostic Radiology (minor surgery), Radiology (major invasive).

(10) The contribution rate for Category 10 providers shall not exceed $7,800 and includes: Anesthesia (pain management including local, regional & epidural.

(11) The contribution rate for Category 11 providers shall not exceed $8,900 and includes: Colon and/or Rectal surgery, Dermatology (surgery includes liposuction), Emergency Medicine (no major surgery), Endocrinology (surgery), Geriatrics (surgery), Neoplastic Diseases (surgery), Nephrology (surgery), Ophthalmology (ocular plastic), Oral Maxillofacial Surgery, and Otorhinolaryngology (surgery and cosmetic).

(12) The contribution rate for Category 12 providers shall not exceed $10,600 and includes: Endocrinology (reproductive), Family/General Practice (not primarily engaged in surgery but includes abortions, obstetrics with caesarian sections and hysterectomies combined not to exceed five per month and includes anesthesia, not to include 3 hours per week), Physicians assisting in surgery and Podiatry.

(13) The contribution rate for Category 13 providers shall not exceed $12,500 and includes: Plastic Surgery (no other classification).

(14) The contribution rate for Category 14 providers shall not exceed $13,200 and includes: Abdominal Surgery, General Surgery (no other classification), Gynecological Surgery, Hand and Foot Surgery, and Orthopedic Surgery (no spinal).

(15) The contribution rate for Category 15 providers shall not exceed $14,500 and includes: Weight Reduction Surgery.

(16) The contribution rate for Category 16 providers shall not exceed $15,600 and includes: Orthopedic Surgery.

(17) The contribution rate for Category 17 providers shall not exceed $17,500 and includes: Cardiac Surgery, Neurological Surgery (limited to the back), Thoracic Surgery, Traumatic Surgery, and Vascular Surgery.

(18) The contribution rate for Category 18 providers shall not exceed $19,500 and includes: Obstetrics and gynecology surgery.

(19) The contribution rate for Category 19 providers shall not exceed $25,300 and includes: Neurological Surgery (including children).

Notwithstanding the limitations above, the specialty component of the annual contribution rate may be increased by the percentage change per year in the medical care component of the consumer price index for all urban consumers.

(c) The contribution determined under this Code section shall be payable by each provider by January 1 of each year. If any provider fails to pay the contribution determined under

this section, the board shall notify such provider by certified or registered mail that such provider's license shall be subject to revocation if the contribution is not paid within 30 days from the date of the notice.

(d) A provider who fails to pay the contribution amount determined under this Code section within 30 days from the date of the receipt of the notice shall have his or her license revoked by the Georgia Composite Medical Board or other relevant regulatory board as appropriate.

(e) All amounts collected under the provisions of this Code section shall be paid into the state treasury and are intended to be used for the expenses of administration of this chapter and the compensation schedule.

51-13-9.

The board shall annually submit, beginning on July 1, 2017, a report that describes the filing and disposition of applications in the prior calendar year. The report shall include, in the aggregate, the number of applications, the disposition of such applications, and compensation awarded. The report shall also provide recommendations, if any, regarding legislative changes that would improve the efficiency of the functions of the Patient Compensation System. The report shall be provided to the Governor, the Lieutenant Governor, and the Speaker of the House of Representatives."

SECTION 3.

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

SECTION 4.

(a) This Act shall become effective upon its approval by the Governor or upon its becoming law without such approval.

(b) It is the intent of the General Assembly to apply the provisions of this Act to prior medical injuries resulting from medical treatment provided on or after January 1, 2016.

SECTION 5.

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