

Senate Bill 141

By: Senators Beach of the 21st, Gooch of the 51st, Albers of the 56th and Miller of the 49th

A BILL TO BE ENTITLED
AN ACT

1 To establish the "Patient Injury Act"; to amend Title 51 of the Official Code of Georgia
2 Annotated, relating to torts, so as to create an alternative to medical malpractice litigation
3 whereby patients are compensated for medical injuries; to provide for a short title; to provide
4 for legislative findings and intent; to provide for definitions; to establish the Patient
5 Compensation System and the Patient Compensation Board; to provide for committees; to
6 provide for the filing of and disposition of applications; to provide for review by an
7 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 style="text-align:center">**SECTION 1.**

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

16 style="text-align:center">"CHAPTER 13

17 51-13-1.

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

19 51-13-2.

20 As used in this chapter, the term:

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

- 23 (2) 'Application' means a request for investigation by the Patient Compensation System
 24 of an alleged occurrence of a medical injury.
- 25 (3) 'Board' means the Patient Compensation Board as created in Code Section 51-13-4.
- 26 (4) 'Collateral source' means any payments made to the applicant, or made on his or her
 27 behalf, by or pursuant to:
- 28 (A) The United States Social Security Act; any federal, state, or local income disability
 29 act; or any other public programs providing medical expenses, disability payments, or
 30 other similar benefits, except as prohibited by federal law.
- 31 (B) Any health, sickness, or income disability insurance; automobile accident
 32 insurance that provides health benefits or income disability coverage; and any other
 33 similar insurance benefits, except life insurance benefits available to the applicant,
 34 whether purchased by the applicant or provided by others.
- 35 (C) Any contract or agreement of any group, organization, partnership, or corporation
 36 to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health
 37 care services.
- 38 (D) Any contractual or voluntary wage continuation plan provided by employers or by
 39 any other system intended to provide wages during a period of disability.
- 40 (5) 'Committee' means, as the context requires, the Medical Review Committee or the
 41 Compensation Committee.
- 42 (6) 'Compensation schedule' means a schedule of damages for medical injuries.
- 43 (7) 'Department' means the Department of Community Health.
- 44 (8) 'Independent medical review panel,' or 'panel,' means a multidisciplinary panel
 45 convened by the chief medical officer to review each application.
- 46 (9)(A) 'Medical injury' means a personal injury or wrongful death due to medical
 47 treatment, including a missed diagnosis, which would have been avoided:
- 48 (i) For care provided by an individual provider, under the care of an experienced
 49 specialist provider practicing in the same field of care under the same or similar
 50 circumstances or, for a general practitioner provider, an experienced general
 51 practitioner provider practicing under the same circumstances; or
- 52 (ii) For care provided by a provider in a system of care, if rendered within an optimal
 53 system of care under the same or similar circumstances.
- 54 (B) A medical injury shall only include consideration of an alternate course of
 55 treatment if the harm could have been avoided through a different but equally effective
 56 manner with respect to the treatment of the underlying condition. In addition, a medical
 57 injury shall only include consideration of information that would have been known to
 58 an experienced specialist or readily available to an optimal system of care at the time
 59 of the medical treatment.

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

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

65 (11) 'Panelist' means a hospital administrator, a person licensed under Chapter 9, 10A,
 66 11, 11A, 26, 27, 28, 30, 33, 34, 35, 39, or 44 of Title 43, or any other person involved in
 67 the management of a health care facility deemed appropriate by the board.

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

70 (13) 'Provider' means a hospital or other health care facility licensed as such under
 71 Chapter 7 of Title 31, which includes a nursing home or skilled nursing facility among
 72 others, or any person licensed under Chapter 4 of Title 26 or under Chapter 9, 10A, 11,
 73 11A, 26, 27, 28, 30, 33, 34, 35, 39, or 44 of Title 43. The term shall also include any
 74 corporation, professional corporation, partnership, limited liability company, limited
 75 liability partnership, authority, or other entity comprised of such providers.

76 51-13-3.

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

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

83 (3) The General Assembly finds that, even for patients who are able to obtain legal
 84 representation, the delay to obtain compensation is averaging approximately five years,
 85 creating a significant hardship for patients and their caregivers who often need access to
 86 immediate care and compensation.

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

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

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

98 (b)(1) The General Assembly intends to create an alternative to medical malpractice
99 litigation whereby patients are fairly and expeditiously compensated for avoidable
100 medical injuries. This alternative, as provided in this chapter, is intended to significantly
101 reduce the practice of defensive medicine, thereby reducing health care costs, increasing
102 the number of physicians practicing in this state, and providing patients fair and timely
103 compensation without the expense and delay of the court system.

104 (2) The General Assembly intends that the definition of 'medical injury' encompass a
105 broader range of personal injuries as compared to a negligence standard, such that a
106 greater number of applications qualify for compensation under this chapter as compared
107 to claims filed under a negligence standard.

108 (3) The General Assembly intends that applications filed under this chapter shall not
109 constitute a claim for medical malpractice, and any action on such applications under this
110 chapter shall not constitute a judgment or adjudication for medical malpractice, and thus
111 professional liability carriers are not obligated to report such applications or actions on
112 such applications to the National Practitioner Data Bank.

113 (4) The General Assembly further intends that because the Patient Compensation System
114 has the primary duty to determine the validity and compensation of each application, an
115 insurer shall not be subject to a statutory or common law bad faith cause of action relating
116 to an application filed under this chapter.

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

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

132 51-13-4.

133 (a) The Patient Compensation System is created and shall be administratively housed
134 within the department. The Patient Compensation System is a separate budget entity that
135 shall be responsible for its administrative functions and shall not be subject to control,
136 supervision, or direction by the department in any manner. The Patient Compensation
137 System shall administer the provisions of this chapter.

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

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

143 (A) Five of the members shall be appointed by, and serve at the pleasure of, the
144 Governor, one of whom shall be a licensed physician who actively practices in this
145 state, one of whom shall be an executive in the business community, one of whom shall
146 be a hospital administrator, one of whom shall be a certified public accountant who
147 actively practices in this state, and one of whom shall be an attorney.

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

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

154 (2) Each member shall be appointed for a 4-year term. For the purpose of providing
155 staggered terms, of the initial appointments, the five members appointed by the Governor
156 shall be appointed to 2-year terms and the remaining six members shall be appointed to
157 3-year terms. If a vacancy occurs on the board before the expiration of a term, the original
158 appointing authority shall appoint a successor to serve the unexpired portion of the term.

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

161 (4) The first meeting of the board shall be held no later than August 1, 2013. Thereafter,
162 the board shall meet at least quarterly upon the call of the chair. A majority of the board
163 members constitutes a quorum. Meetings may be held by teleconference, web conference,
164 or other electronic means.

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

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

206 (E) The chief medical officer shall be a physician licensed under Chapter 34 of Title
 207 43 who shall manage the Office of Medical Review. The chief medical officer shall
 208 recommend to the Medical Review Committee a qualified list of multidisciplinary
 209 panelists for independent medical review panels. In addition, the chief medical officer
 210 shall convene independent medical review panels as necessary to review applications.

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

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

213 (1) The chief medical officer shall manage the Office of Medical Review. The Office of
 214 Medical Review shall evaluate and, as necessary, investigate all applications in
 215 accordance with this chapter. For the purpose of an investigation of an application, the
 216 office shall have the power to administer oaths, take depositions, issue subpoenas, compel
 217 the attendance of witnesses and the production of papers, documents, and other evidence,
 218 and obtain patient records pursuant to the applicant's release of protected health
 219 information.

220 (2) The chief compensation officer shall manage the Office of Compensation. The office
 221 shall allocate compensation for each application in accordance with the compensation
 222 schedule.

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

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

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

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

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

240 (2) Members of each committee shall serve 2-year terms, within their respective terms
 241 as board members. If a vacancy occurs on a committee, the board shall appoint a

242 successor to serve the unexpired portion of the term. A committee member who is
243 removed or resigns from the board shall be removed from the committee.

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

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

248 (5)(A) The Medical Review Committee shall recommend to the board a
249 comprehensive, multidisciplinary list of panelists who shall serve on the independent
250 medical review panels as needed.

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

253 (i) A compensation schedule formulated such that the initial compensation schedule
254 plus the initial amount of contributions by providers shall not exceed the prior fiscal
255 year aggregate cost of medical malpractice as determined by an independent actuary
256 at the request of the board. In addition, initial damage payments for each type of
257 injury shall be no less than the average indemnity payment reported by the Physician
258 Insurers Association of America or its successor organization for like injuries with
259 like severity for the prior fiscal year. Thereafter, the Compensation Committee shall
260 annually review the compensation schedule, and, if necessary, recommend a revised
261 schedule, such that a projected increase in the upcoming fiscal year aggregate cost of
262 medical malpractice, which shall include insured and self-insured providers, shall not
263 exceed the percentage change from the prior year in the medical care component of
264 the consumer price index for all urban consumers.

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

266 (iii) Guidelines for the apportionment of compensation among multiple providers,
267 which guidelines shall be based on the historical apportionment among multiple
268 providers for like injuries with like severity.

269 (e) The chief medical officer shall convene an independent medical review panel to
270 evaluate whether an application constitutes a medical injury. Each panel shall be composed
271 of an odd number of at least three panelists chosen from the list of panelists recommended
272 by the Medical Review Committee and approved by the board, and shall be convened upon
273 the call of the chief medical officer. Each panelist shall be paid a stipend as determined by
274 the board for his or her service on the panel. In order to expedite the review of applications,
275 the chief medical officer may, whenever practicable, group related applications together
276 for consideration by a single panel.

277 (f) A board member, panelist, or employee of the Patient Compensation System may not
278 engage in any conduct that constitutes a conflict of interest. For purposes of this subsection,

279 a 'conflict of interest' means a situation in which the private interest of a board member,
280 panelist, or employee could influence his or her judgment in the performance of his or her
281 duties under this chapter. A board member, panelist, or employee shall immediately
282 disclose in writing the presence of a conflict of interest when the board member, panelist,
283 or employee knows or should have known that the factual circumstances surrounding a
284 particular application constitutes or constituted a conflict of interest. A board member,
285 panelist, or employee who violates this subsection shall be subject to disciplinary action
286 as determined by the board. A conflict of interest includes, but is not limited to:

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

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

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

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

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

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

302 (4) Payment of compensation awards through periodic payments and the apportionment
303 of compensation among multiple providers, as recommended by the Compensation
304 Committee.

305 51-13-5.

306 (a) In order to obtain compensation for a medical injury, a person, or his or her legal
307 representative, shall file an application with the Patient Compensation System. The
308 application shall include the following:

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

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

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

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

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

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

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

325 (c) An application shall be filed within the time frames specified in Code Section 9-3-71
326 for medical malpractice actions.

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

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

333 51-13-6.

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

337 (1) If the Office of Medical Review determines that the application, prima facie,
338 constitutes a medical injury, the office shall immediately notify, by registered or certified
339 mail, each provider named in the application and, for providers that are not self-insured,
340 the insurer that provides coverage for the provider. The notification shall inform the
341 provider that he or she may support the application to expedite the processing of the
342 application. A provider shall have 15 days from the receipt of notification of an
343 application to support the application. If the provider supports the application, the Office
344 of Medical Review shall review the application in accordance with subsection (b) of this
345 Code section.

346 (2) If the Office of Medical Review determines that the application does not, prima facie,
347 constitute a medical injury, the office shall send a rejection letter to the applicant by
348 registered or certified mail, which shall inform the applicant of his or her right of appeal.
349 The applicant shall have 15 days from the date of the receipt of the letter in which to
350 appeal the determination of the office pursuant to Code Section 51-13-7.

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

360 (c) If the Office of Medical Review determines that the application, prima facie,
361 constitutes a medical injury, and the provider does not elect to support the application, the
362 office shall complete a thorough investigation of the application within 60 days after the
363 determination by the office. The investigation shall be conducted by a multidisciplinary
364 team with relevant clinical expertise and shall include a thorough investigation of all
365 available documentation, witnesses, and other information. Within 15 days after the
366 completion of the investigation, the chief medical officer shall allow the applicant and the
367 provider to access records, statements, and other information obtained in the course of its
368 investigation, in accordance with relevant state and federal laws. Within 30 days after the
369 completion of the investigation, the chief medical officer shall convene an independent
370 medical review panel to determine whether the application constitutes a medical injury.
371 The independent medical review panel shall have access to all redacted information
372 obtained by the office in the course of its investigation of the application, and shall make
373 a written determination within 10 days after the convening of the panel, which written
374 determination shall be immediately provided to the applicant and the provider. The
375 standard of review shall be a preponderance of the evidence.

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

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

386 (d) If an independent medical review panel finds that an application constitutes a medical
387 injury pursuant to subsection (c) of this Code section, and all appeals of that finding have

388 been exhausted by the provider pursuant to Code Section 51-13-7, the Office of
389 Compensation shall, within 30 days after either the finding of the panel or the exhaustion
390 of all appeals of that finding, whichever occurs later, make a written determination of an
391 award of compensation in accordance with the compensation schedule and the findings of
392 the panel. The office shall notify the applicant and the provider by registered or certified
393 mail of the amount of compensation, and shall additionally explain to the applicant the
394 process to appeal the determination of the office. The applicant shall have 15 days from the
395 receipt of the letter to appeal the determination of the office pursuant to Code Section
396 51-13-7.

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

401 (f) Within 15 days after either the acceptance of compensation by the applicant or the
402 conclusion of all appeals pursuant to Code Section 51-13-7, the provider, or for a provider
403 who has insurance coverage, the insurer, shall remit the compensation award to the Patient
404 Compensation System, which shall immediately provide compensation to the applicant in
405 accordance with the final compensation award. Beginning 45 days after the acceptance of
406 compensation by the applicant or the conclusion of all appeals pursuant to Code Section
407 51-13-7, whichever occurs later, an unpaid award shall begin to accrue interest at the rate
408 of 18 percent per year. An applicant may petition the Superior Court of Fulton County for
409 enforcement of an award under this chapter.

410 (g) A physician who is the subject of an application under this chapter shall be found to
411 have committed medical malpractice only upon a specific finding to that effect by the
412 Georgia Composite Medical Board.

413 (h) The Patient Compensation System shall provide the department with electronic access
414 to applications in which a medical injury was determined to exist, related to persons
415 licensed under Chapter 9, 10A, 11, 11A, 26, 27, 28, 30, 33, 34, 35, 39, or 44 of Title 43,
416 where the provider represents an imminent risk of harm to the public. The department shall
417 review such applications to determine whether any of the incidents that resulted in the
418 application potentially involved conduct by the licensee that is subject to disciplinary
419 action, in which case the provisions of Code Section 43-34-8 shall apply.

420 51-13-7.

421 (a) An administrative law judge shall hear and determine appeals filed by applicants or
422 providers pursuant to Code Section 51-13-6 and shall exercise the full power and authority
423 granted to him or her, as necessary, to carry out the purposes of such section. The

424 administrative law judge shall be limited in his or her review to determining whether the
425 Office of Medical Review, the independent medical review panel, or Office of
426 Compensation, as appropriate, has faithfully followed the requirements of this chapter and
427 rules adopted hereunder in reviewing applications. If the administrative law judge
428 determines that such requirements were not followed in reviewing an application, he or she
429 shall require the chief medical officer to either reconvene the original panel or convene a
430 new panel, or require the Office of Compensation to redetermine the compensation amount,
431 in accordance with the determination of the administrative law judge.

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

437 (c) Upon a written petition by either the applicant or the provider, an administrative law
438 judge may grant, for good cause, an extension of any of the time periods specified in this
439 chapter.

440 51-13-8.

441 (a) The board shall annually determine a contribution that shall be paid by each provider
442 for the expense of the administration of this chapter. The contribution amount shall be
443 determined by January 1 of each year, and shall be based on the anticipated expenses of the
444 administration of this chapter for the next state fiscal year.

445 (b) The contribution rate shall not exceed the following amounts:

446 (1) For an individual licensed under Chapter 11 of Title 43, or Chapter 26 of Title 43,
447 with the exception of a certified registered nurse anesthetist, \$100.00 per licensee.

448 (2) For a hospital or ambulatory surgery center licensed under Chapter 7 of Title 31,
449 \$200.00 per bed. The contribution for the initial fiscal year shall be \$100.00 per bed.

450 (3) For an anesthesiology assistant or physician assistant licensed under Chapter 34 of
451 Title 43 or a certified registered nurse anesthetist certified under Chapter 26 of Title 43,
452 \$250.00 per licensee.

453 (4) For a physician licensed under Chapter 9 or 34 of Title 43, \$600.00 per licensee. The
454 contribution for the initial fiscal year shall be \$500.00 per licensee.

455 (5) For any other provider not otherwise described in this subsection, \$2,500.00 per
456 registrant or licensee.

457 (c) The contribution determined under this code section shall be payable by each provider
458 on July 1 of the next state fiscal year. Each provider shall pay the contribution amount
459 within 30 days from the date that notice is delivered to the provider. If any provider fails

460 to pay the contribution determined under this section within 30 days, the board shall notify
 461 such provider by certified or registered mail that such provider's license shall be subject to
 462 revocation if the contribution is not paid within 60 days from the date of the original notice.

463 (d) A provider who fails to pay the contribution amount determined under this code section
 464 within 60 days from the date of the receipt of the original notice shall be subject to a
 465 licensure revocation action by the Department of Community Health or the relevant
 466 regulatory board, as appropriate.

467 (e) All amounts collected under the provisions of this code section shall be paid into the
 468 trust fund established in Code Section 51-13-10.

469 51-13-9.

470 The board shall annually submit, beginning on October 1, 2013, a report that describes the
 471 filing and disposition of applications in the prior fiscal year. The report shall include, in the
 472 aggregate, the number of applications, the disposition of such applications, and
 473 compensation awarded. The report shall also provide recommendations, if any, regarding
 474 legislative changes that would improve the efficiency of the functions of the Patient
 475 Compensation System. The report shall be provided to the Governor, the Lieutenant
 476 Governor, and the Speaker of the House of Representatives.

477 51-13-10.

478 (a) There is created in the state treasury a special fund to be designated as the Patient
 479 Compensation System Trust Fund, which shall be used in the operation of the Patient
 480 Compensation System in the performance of the various functions and duties required of
 481 it under this chapter. The trust fund is established for the deposit of contributions required
 482 to be paid by providers pursuant to Code Section 51-13-8.

483 (b) Any balance in the trust fund at the end of any fiscal year shall remain in the trust fund
 484 at the end of the year and shall be available for carrying out the purposes of the trust fund."

485 **SECTION 2.**

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

493

SECTION 3.

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

496 (b) It is the intent of the General Assembly to apply the provisions of this Act to prior
497 medical injuries for which a notice of intent to initiate litigation has not been mailed before
498 the effective date of this Act.

499

SECTION 4.

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