1 HOUSE BILL NO. 1987

2 AMENDMENT IN THE NATURE OF A SUBSTITUTE

3 (Proposed by the House Committee on Health, Welfare and Institutions

4 on ________________)

5 (Patron Prior to Substitute--Delegate Adams, D.M.)

6 A BILL to amend and reenact §§ 32.1-325, 38.2-3418.16, and 54.1-3303 of the Code of Virginia, relating
7 to telemedicine.

8 **Be it enacted by the General Assembly of Virginia:**

9 **1. That §§ 32.1-325, 38.2-3418.16, and 54.1-3303 of the Code of Virginia are amended and reenacted**
10 **as follows:**

11 **§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health**
12 **and Human Services pursuant to federal law; administration of plan; contracts with health care**
13 **providers.**

14 A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time
15 to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance
16 services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The
17 Board shall include in such plan:

18 1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21,
19 placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing
20 agencies by the Department of Social Services or placed through state and local subsidized adoptions to
21 the extent permitted under federal statute;

22 2. A provision for determining eligibility for benefits for medically needy individuals which
23 disregards from countable resources an amount not in excess of $3,500 for the individual and an amount
24 not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses
25 of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life
26 insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of

27 such policies has been excluded from countable resources and (ii) the amount of any other revocable or
28 irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the
29 individual's or his spouse's burial expenses;
30 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically
31 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the
32 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used
33 as the principal residence and all contiguous property. For all other persons, a home shall mean the house
34 and lot used as the principal residence, as well as all contiguous property, as long as the value of the land,
35 exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of
36 home as provided here is more restrictive than that provided in the state plan for medical assistance
37 services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as
38 the principal residence and all contiguous property essential to the operation of the home regardless of
39 value;
40 4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who
41 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per
42 admission;
43 5. A provision for deducting from an institutionalized recipient's income an amount for the
44 maintenance of the individual's spouse at home;
45 6. A provision for payment of medical assistance on behalf of pregnant women which provides for
46 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most
47 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American
48 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards
49 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and
50 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the
51 children which are within the time periods recommended by the attending physicians in accordance with
52 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines

53 or Standards shall include any changes thereto within six months of the publication of such Guidelines or
54 Standards or any official amendment thereto;
55 7. A provision for the payment for family planning services on behalf of women who were
56 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such
57 family planning services shall begin with delivery and continue for a period of 24 months, if the woman
58 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the
59 purposes of this section, family planning services shall not cover payment for abortion services and no
60 funds shall be used to perform, assist, encourage or make direct referrals for abortions;
61 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow
62 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast
63 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a
64 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant.
65 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;
66 9. A provision identifying entities approved by the Board to receive applications and to determine
67 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate
68 contact information, including the best available address and telephone number, from each applicant for
69 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant
70 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et
71 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance
72 directives and how the applicant may make an advance directive;
73 10. A provision for breast reconstructive surgery following the medically necessary removal of a
74 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained,
75 for all medically necessary indications. Such procedures shall be considered noncosmetic;
76 11. A provision for payment of medical assistance for annual pap smears;
77 12. A provision for payment of medical assistance services for prostheses following the medically
78 necessary complete or partial removal of a breast for any medical reason;

79 13. A provision for payment of medical assistance which provides for payment for 48 hours of
80 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of
81 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for
82 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring
83 the provision of inpatient coverage where the attending physician in consultation with the patient
84 determines that a shorter period of hospital stay is appropriate;
85 14. A requirement that certificates of medical necessity for durable medical equipment and any
86 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician
87 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days
88 from the time the ordered durable medical equipment and supplies are first furnished by the durable
89 medical equipment provider;
90 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons
91 age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines
92 of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations,
93 all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA
94 testing" means the analysis of a blood sample to determine the level of prostate specific antigen;
95 16. A provision for payment of medical assistance for low-dose screening mammograms for
96 determining the presence of occult breast cancer. Such coverage shall make available one screening
97 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
98 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
99 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
100 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
101 radiation exposure of less than one rad mid-breast, two views of each breast;
102 17. A provision, when in compliance with federal law and regulation and approved by the Centers
103 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
104 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
105 program and may be provided by school divisions;

106 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
107 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
108 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
109 application of the procedure in treatment of the specific condition have been clearly demonstrated to be
110 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
111 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant
112 center where the surgery is proposed to be performed have been used by the transplant team or program
113 to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed
114 and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an
115 irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range
116 of physical and social functioning in the activities of daily living;
117 19. A provision for payment of medical assistance for colorectal cancer screening, specifically
118 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate
119 circumstances radiologic imaging, in accordance with the most recently published recommendations
120 established by the American College of Gastroenterology, in consultation with the American Cancer
121 Society, for the ages, family histories, and frequencies referenced in such recommendations;
122 20. A provision for payment of medical assistance for custom ocular prostheses;
123 21. A provision for payment for medical assistance for infant hearing screenings and all necessary
124 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United
125 States Food and Drug Administration, and as recommended by the national Joint Committee on Infant
126 Hearing in its most current position statement addressing early hearing detection and intervention
127 programs. Such provision shall include payment for medical assistance for follow-up audiological
128 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and
129 performed by a licensed audiologist to confirm the existence or absence of hearing loss;
130 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer
131 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer
132 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease

133 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under
134 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including
135 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under
136 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise
137 eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v)
138 have not attained age 65. This provision shall include an expedited eligibility determination for such
139 women;

140 23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment
141 and services delivery, of medical assistance services provided to medically indigent children pursuant to
142 this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the
143 FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for
144 both programs;

145 24. A provision, when authorized by and in compliance with federal law, to establish a public-
146 private long-term care partnership program between the Commonwealth of Virginia and private insurance
147 companies that shall be established through the filing of an amendment to the state plan for medical
148 assistance services by the Department of Medical Assistance Services. The purpose of the program shall
149 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for
150 such services through encouraging the purchase of private long-term care insurance policies that have
151 been designated as qualified state long-term care insurance partnerships and may be used as the first source
152 of benefits for the participant's long-term care. Components of the program, including the treatment of
153 assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and
154 applicable federal guidelines;

155 25. A provision for the payment of medical assistance for otherwise eligible pregnant women
156 during the first five years of lawful residence in the United States, pursuant to § 214 of the Children's
157 Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3);~~ and~~

158 26. A provision for the payment of medical assistance for medically necessary health care services
159 provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or

160 whether the patient is accompanied by a health care provider at the time such services are provided. No
161 health care provider who provides health care services through telemedicine services shall be required to
162 use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

163 For the purposes of this subdivision, "originating site" means any location where the patient is
164 located, including any medical care facility or office of a health care provider, the home of the patient, the
165 patient's place of employment, or any public or private primary or secondary school or postsecondary
166 institution of higher education at which the person to whom telemedicine services are provided is located;
167 and

168 27. A provision for payment of medical assistance for remote patient monitoring services provided
169 via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically complex
170 infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three
171 months following the date of such surgery; and (v) patients with a chronic health condition who have had
172 two or more hospitalizations or emergency department visits related to such chronic health condition in
173 the previous 12 months. For the purposes of this subdivision, "remote patient monitoring services" means
174 the use of digital technologies to collect medical and other forms of health data from patients in one
175 location and electronically transmit that information securely to health care providers in a different
176 location for analysis, interpretation, and recommendations, and management of the patient. "Remote
177 patient monitoring services" includes monitoring of clinical patient data such as weight, blood pressure,
178 pulse, pulse oximetry, blood glucose, and other patient physiological data, treatment adherence
179 monitoring, and interactive videoconferencing with or without digital image upload.

180 B. In preparing the plan, the Board shall:

181 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided
182 and that the health, safety, security, rights and welfare of patients are ensured.

183 2. Initiate such cost containment or other measures as are set forth in the appropriation act.

184 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the
185 provisions of this chapter.

186 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations
187 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social services.
188 For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with
189 local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include
190 the projected costs/savings to the local boards of social services to implement or comply with such
191 regulation and, where applicable, sources of potential funds to implement or comply with such regulation.
192 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in
193 accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities
194 With Deficiencies."
195 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card,
196 or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each
197 recipient of medical assistance services, and shall upon any changes in the required data elements set forth
198 in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective
199 information as may be required to electronically process a prescription claim.
200 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement
201 for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,
202 regardless of any other provision of this chapter, such amendments to the state plan for medical assistance
203 services as may be necessary to conform such plan with amendments to the United States Social Security
204 Act or other relevant federal law and their implementing regulations or constructions of these laws and
205 regulations by courts of competent jurisdiction or the United States Secretary of Health and Human
206 Services.
207 In the event conforming amendments to the state plan for medical assistance services are adopted,
208 the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
209 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
210 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
211 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
212 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the

213 Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session
214 of the General Assembly unless enacted into law.

215 D. The Director of Medical Assistance Services is authorized to:

216 1. Administer such state plan and receive and expend federal funds therefor in accordance with
217 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the
218 performance of the Department's duties and the execution of its powers as provided by law.

219 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other
220 health care providers where necessary to carry out the provisions of such state plan. Any such agreement
221 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is
222 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new
223 agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement
224 or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

225 3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
226 agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony,
227 or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider
228 as required by 42 C.F.R. § 1002.212.

229 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
230 agreement or contract, with a provider who is or has been a principal in a professional or other corporation
231 when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-
232 315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
233 program pursuant to 42 C.F.R. Part 1002.

234 5. Terminate or suspend a provider agreement with a home care organization pursuant to
235 subsection E of § 32.1-162.13.

236 For the purposes of this subsection, "provider" may refer to an individual or an entity.

237 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
238 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. §
239 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative

240 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
241 the date of receipt of the notice.

242 The Director may consider aggravating and mitigating factors including the nature and extent of
243 any adverse impact the agreement or contract denial or termination may have on the medical care provided
244 to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to
245 subsection D, the Director may determine the period of exclusion and may consider aggravating and
246 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant
247 to 42 C.F.R. § 1002.215.

248 F. When the services provided for by such plan are services which a marriage and family therapist,
249 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed
250 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,
251 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or
252 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter
253 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which
254 reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social
255 workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon
256 reasonable criteria, including the professional credentials required for licensure.

257 G. The Board shall prepare and submit to the Secretary of the United States Department of Health
258 and Human Services such amendments to the state plan for medical assistance services as may be
259 permitted by federal law to establish a program of family assistance whereby children over the age of 18
260 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of
261 providing medical assistance under the plan to their parents.

262 H. The Department of Medical Assistance Services shall:

263 1. Include in its provider networks and all of its health maintenance organization contracts a
264 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have
265 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse
266 and neglect, for medically necessary assessment and treatment services, when such services are delivered

267 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a
268 provider with comparable expertise, as determined by the Director.

269 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an
270 exception, with procedural requirements, to mandatory enrollment for certain children between birth and
271 age three certified by the Department of Behavioral Health and Developmental Services as eligible for
272 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

273 3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to
274 contractors and enrolled providers for the provision of health care services under Medicaid and the Family
275 Access to Medical Insurance Security Plan established under § 32.1-351.

276 4. Require any managed care organization with which the Department enters into an agreement
277 for the provision of medical assistance services to include in any contract between the managed care
278 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or
279 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the
280 managed care organization's managed care plans. For the purposes of this subdivision:

281 "Pharmacy benefits management" means the administration or management of prescription drug
282 benefits provided by a managed care organization for the benefit of covered individuals.

283 "Pharmacy benefits manager" means a person that performs pharmacy benefits management.

284 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits
285 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price
286 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly
287 pays the pharmacist or pharmacy for pharmacist services.

288 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible
289 recipients with special needs. The Board shall promulgate regulations regarding these special needs
290 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special
291 needs as defined by the Board.

292 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public
293 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by

294 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law
295 and regulation.

296 **§ 38.2-3418.16. Coverage for telemedicine services.**

297 A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or
298 group accident and sickness insurance policies providing hospital, medical and surgical, or major medical
299 coverage on an expense-incurred basis; each corporation providing individual or group accident and
300 sickness subscription contracts; and each health maintenance organization providing a health care plan for
301 health care services shall provide coverage for the cost of such health care services provided through
302 telemedicine services, as provided in this section.

303 B. As used in this section:

304 "Originating site" means the location where the patient is located at the time services are provided
305 by a health care provider through telemedicine services.

306 "Remote patient monitoring services" means the delivery of home health services using
307 telecommunications technology to enhance the delivery of home health care, including monitoring of
308 clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other
309 condition-specific data; medication adherence monitoring; and interactive video conferencing with or
310 without digital image upload.

311 "Telemedicine services" as it pertains to the delivery of health care services, means the use of
312 electronic technology or media, including interactive audio or video, for the purpose of diagnosing or
313 treating a patient, providing remote patient monitoring services, or consulting with other health care
314 providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the
315 patient is accompanied by a health care provider at the time such services are provided. "Telemedicine
316 services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or
317 online questionnaire. Nothing in this section shall preclude coverage for a service that is not a telemedicine
318 service, including real-time audio-only telehealth services.

319 C. An insurer, corporation, or health maintenance organization shall not exclude a service for
320 coverage solely because the service is provided through telemedicine services and is not provided through

321 face-to-face consultation or contact between a health care provider and a patient for services appropriately
322 provided through telemedicine services.

323 D. An insurer, corporation, or health maintenance organization shall not be required to reimburse
324 the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine
325 services; however, such insurer, corporation, or health maintenance organization shall reimburse the
326 treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured
327 delivered through telemedicine services on the same basis that the insurer, corporation, or health
328 maintenance organization is responsible for coverage for the provision of the same service through face-
329 to-face consultation or contact. No insurer, corporation, or health maintenance organization shall require
330 a provider to use proprietary technology or applications in order to be reimbursed for providing
331 telemedicine services.

332 E. Nothing shall preclude the insurer, corporation, or health maintenance organization from
333 undertaking utilization review to determine the appropriateness of telemedicine services, provided that
334 such appropriateness is made in the same manner as those determinations are made for the treatment of
335 any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization
336 review shall not require pre-authorization of emergent telemedicine services.

337 F. An insurer, corporation, or health maintenance organization may offer a health plan containing
338 a deductible, copayment, or coinsurance requirement for a health care service provided through
339 telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the
340 deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face
341 diagnosis, consultation, or treatment.

342 G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime
343 dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum
344 that applies in the aggregate to all items and services covered under the policy, or impose upon any person
345 receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any
346 policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or

347 services, that is not equally imposed upon all terms and services covered under the policy, contract, or
348 plan.

349 H. The requirements of this section shall apply to all insurance policies, contracts, and plans
350 delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021,
351 or at any time thereafter when any term of the policy, contract, or plan is changed or any premium
352 adjustment is made.

353 I. This section shall not apply to short-term travel, accident-only, or limited or specified disease
354 policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage
355 under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under
356 federal governmental plans.

357 J. The coverage required by this section shall include the use of telemedicine technologies as it
358 pertains to medically necessary remote patient monitoring services to the full extent that these services are
359 available.

360 K. Prescribing of controlled substances via telemedicine shall comply with the requirements of §
361 54.1-3303 and all applicable federal law.

362 **§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic**
363 **purposes only.**

364 A. A prescription for a controlled substance may be issued only by a practitioner of medicine,
365 osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled
366 substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant
367 pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of
368 Chapter 32.

369 B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona
370 fide practitioner-patient relationship or veterinarian-client-patient relationship. If a practitioner is
371 providing expedited partner therapy consistent with the recommendations of the Centers for Disease
372 Control and Prevention, then a bona fide practitioner-patient relationship shall not be required.

373 A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused
374 to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the
375 benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate
376 examination of the patient, either physically or by the use of instrumentation and diagnostic equipment
377 through which images and medical records may be transmitted electronically; and (iv) initiated additional
378 interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side
379 effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii)
380 shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in
381 the same group as the practitioner prescribing the controlled substance, or a consulting practitioner.

382 A practitioner who has established a bona fide practitioner-patient relationship with a patient in
383 accordance with the provisions of this subsection may prescribe Schedule II through VI controlled
384 substances to that patient, including by telemedicine, provided that~~, in cases in which the practitioner has~~
385 ~~performed the examination required pursuant to clause (iii) by use of instrumentation and diagnostic~~
386 ~~equipment through which images and medical records may be transmitted electronically,~~ the prescribing
387 of such Schedule II through V controlled substance is in compliance with federal requirements for the
388 practice of telemedicine and, if such prescribing is via telemedicine, the prescriber maintains a practice at
389 a physical location in the Commonwealth or makes appropriate referral of patients to a licensed
390 practitioner located in the Commonwealth in order to ensure availability for an in-person examination of
391 the patient when required by the standard of care.

392 For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine
393 services as defined in § 38.2-3418.16, and to the extent allowed under federal law and regulations, or any
394 waiver of federal law or regulation, a prescriber may establish a bona fide practitioner-patient relationship
395 for the purpose of prescribing a Schedule II through V controlled substance, including by telemedicine
396 when consistent with the standard of care, by an examination through face-to-face interactive, two-way,
397 real-time communications services or store-and-forward technologies when all of the following conditions
398 are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b)
399 the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a

400 diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-
401 person care as appropriate to the patient's age and presenting condition, including when the standard of
402 care requires the use of diagnostic testing and performance of a physical examination, which may be
403 carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber
404 is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or
405 enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a
406 participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by
407 the health plan or carrier pursuant to § 38.2-3418.16; and (g) upon request, the prescriber provides patient
408 records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and
409 federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide
410 practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when
411 the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in
412 this paragraph shall apply to~~:~~ (1) a prescriber providing on-call coverage per an agreement with another
413 prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another
414 prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

415 For purposes of this section, a bona fide veterinarian-client-patient relationship is one in which a
416 veterinarian, another veterinarian within the group in which he practices, or a veterinarian with whom he
417 is consulting has assumed the responsibility for making medical judgments regarding the health of and
418 providing medical treatment to an animal as defined in § 3.2-6500, other than an equine as defined in §
419 3.2-6200, a group of agricultural animals as defined in § 3.2-6500, or bees as defined in § 3.2-4400, and
420 a client who is the owner or other caretaker of the animal, group of agricultural animals, or bees has
421 consented to such treatment and agreed to follow the instructions of the veterinarian. Evidence that a
422 veterinarian has assumed responsibility for making medical judgments regarding the health of and
423 providing medical treatment to an animal, group of agricultural animals, or bees shall include evidence
424 that the veterinarian (A) has sufficient knowledge of the animal, group of agricultural animals, or bees to
425 provide a general or preliminary diagnosis of the medical condition of the animal, group of agricultural
426 animals, or bees; (B) has made an examination of the animal, group of agricultural animals, or bees, either

427 physically or by the use of instrumentation and diagnostic equipment through which images and medical
428 records may be transmitted electronically or has become familiar with the care and keeping of that species
429 of animal or bee on the premises of the client, including other premises within the same operation or
430 production system of the client, through medically appropriate and timely visits to the premises at which
431 the animal, group of agricultural animals, or bees are kept; and (C) is available to provide follow-up care.
432 C. A prescription shall only be issued for a medicinal or therapeutic purpose in the usual course of
433 treatment or for authorized research. A prescription not issued in the usual course of treatment or for
434 authorized research is not a valid prescription. A practitioner who prescribes any controlled substance
435 with the knowledge that the controlled substance will be used otherwise than for medicinal or therapeutic
436 purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions
437 of law relating to the distribution or possession of controlled substances.
438 D. No prescription shall be filled unless a bona fide practitioner-patient-pharmacist relationship
439 exists. A bona fide practitioner-patient-pharmacist relationship shall exist in cases in which a practitioner
440 prescribes, and a pharmacist dispenses, controlled substances in good faith to a patient for a medicinal or
441 therapeutic purpose within the course of his professional practice.
442 In cases in which it is not clear to a pharmacist that a bona fide practitioner-patient relationship
443 exists between a prescriber and a patient, a pharmacist shall contact the prescribing practitioner or his
444 agent and verify the identity of the patient and name and quantity of the drug prescribed.
445 Any person knowingly filling an invalid prescription shall be subject to the criminal penalties
446 provided in § 18.2-248 for violations of the provisions of law relating to the sale, distribution or possession
447 of controlled substances.
448 E. Notwithstanding any provision of law to the contrary and consistent with recommendations of
449 the Centers for Disease Control and Prevention or the Department of Health, a practitioner may prescribe
450 Schedule VI antibiotics and antiviral agents to other persons in close contact with a diagnosed patient
451 when (i) the practitioner meets all requirements of a bona fide practitioner-patient relationship, as defined
452 in subsection B, with the diagnosed patient and (ii) in the practitioner's professional judgment, the
453 practitioner deems there is urgency to begin treatment to prevent the transmission of a communicable

454 disease. In cases in which the practitioner is an employee of or contracted by the Department of Health or
455 a local health department, the bona fide practitioner-patient relationship with the diagnosed patient, as
456 required by clause (i), shall not be required.
457 F. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state
458 practitioner of medicine, osteopathy, podiatry, dentistry, optometry, or veterinary medicine, a nurse
459 practitioner, or a physician assistant authorized to issue such prescription if the prescription complies with
460 the requirements of this chapter and the Drug Control Act (§ 54.1-3400 et seq.).
461 G. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to
462 § 54.1-2957.01 may issue prescriptions or provide manufacturers' professional samples for controlled
463 substances and devices as set forth in the Drug Control Act (§ 54.1-3400 et seq.) in good faith to his patient
464 for a medicinal or therapeutic purpose within the scope of his professional practice.
465 H. A licensed physician assistant who is authorized to prescribe controlled substances pursuant to
466 § 54.1-2952.1 may issue prescriptions or provide manufacturers' professional samples for controlled
467 substances and devices as set forth in the Drug Control Act (§ 54.1-3400 et seq.) in good faith to his patient
468 for a medicinal or therapeutic purpose within the scope of his professional practice.
469 I. A TPA-certified optometrist who is authorized to prescribe controlled substances pursuant to
470 Article 5 (§ 54.1-3222 et seq.) of Chapter 32 may issue prescriptions in good faith or provide
471 manufacturers' professional samples to his patients for medicinal or therapeutic purposes within the scope
472 of his professional practice for the drugs specified on the TPA-Formulary, established pursuant to § 54.1-
473 3223, which shall be limited to (i) analgesics included on Schedule II controlled substances as defined in
474 § 54.1-3448 of the Drug Control Act (§ 54.1-3400 et seq.) consisting of hydrocodone in combination with
475 acetaminophen; (ii) oral analgesics included in Schedules III through VI, as defined in §§ 54.1-3450 and
476 54.1-3455 of the Drug Control Act (§ 54.1-3400 et seq.), which are appropriate to relieve ocular pain; (iii)
477 other oral Schedule VI controlled substances, as defined in § 54.1-3455 of the Drug Control Act,
478 appropriate to treat diseases and abnormal conditions of the human eye and its adnexa; (iv) topically
479 applied Schedule VI drugs, as defined in § 54.1-3455 of the Drug Control Act; and (v) intramuscular
480 administration of epinephrine for treatment of emergency cases of anaphylactic shock.

481 J. The requirement for a bona fide practitioner-patient relationship shall be deemed to be satisfied
482 by a member or committee of a hospital's medical staff when approving a standing order or protocol for
483 the administration of influenza vaccinations and pneumococcal vaccinations in a hospital in compliance
484 with § 32.1-126.4.

485 K. Notwithstanding any other provision of law, a prescriber may authorize a registered nurse or
486 licensed practical nurse to approve additional refills of a prescribed drug for no more than 90 consecutive
487 days, provided that (i) the drug is classified as a Schedule VI drug; (ii) there are no changes in the
488 prescribed drug, strength, or dosage; (iii) the prescriber has a current written protocol, accessible by the
489 nurse, that identifies the conditions under which the nurse may approve additional refills; and (iv) the
490 nurse documents in the patient's chart any refills authorized for a specific patient pursuant to the protocol
491 and the additional refills are transmitted to a pharmacist in accordance with the allowances for an
492 authorized agent to transmit a prescription orally or by facsimile pursuant to subsection C of § 54.1-
493 3408.01 and regulations of the Board.

494 **2. That the Department of Medical Assistance Services shall adopt regulations for reimbursement**
495 **for telemedicine services delivered through audio-only telephone, which shall include regulations**
496 **for (i) services that may be delivered via audio-only telephone, (ii) reimbursement rates for services**
497 **delivered via audio-only telephone, and (iii) such other regulations as the Department of Medical**
498 **Assistance Services may deem necessary.**

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