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SENATE BILL NO. 1221

Offered January 9, 2019

Prefiled January 4, 2019

A BILL to amend and reenact §§ 32.1-325, 38.2-3418.16, 54.1-2901, and 54.1-2903 of the Code of Virginia, relating to telemedicine services; coverage and practice.

Patrons—Chafin, Chase, Favola, Boysko, Carrico, Cosgrove, DeSteph, Dunnivant, Mason, Reeves, Sturtevant and Wagner; Delegates: Landes, Morefield, Rasoul and Tyler

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-325, 38.2-3418.16, 54.1-2901, and 54.1-2903 of the Code of Virginia are amended and reenacted as follows:

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

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

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

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were

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SB1221

58 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such  
59 family planning services shall begin with delivery and continue for a period of 24 months, if the woman  
60 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the  
61 purposes of this section, family planning services shall not cover payment for abortion services and no  
62 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

63 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow  
64 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast  
65 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a  
66 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant.  
67 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

68 9. A provision identifying entities approved by the Board to receive applications and to determine  
69 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate  
70 contact information, including the best available address and telephone number, from each applicant for  
71 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant  
72 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et  
73 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance  
74 directives and how the applicant may make an advance directive;

75 10. A provision for breast reconstructive surgery following the medically necessary removal of a  
76 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been  
77 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

78 11. A provision for payment of medical assistance for annual pap smears;

79 12. A provision for payment of medical assistance services for prostheses following the medically  
80 necessary complete or partial removal of a breast for any medical reason;

81 13. A provision for payment of medical assistance which provides for payment for 48 hours of  
82 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of  
83 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for  
84 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring  
85 the provision of inpatient coverage where the attending physician in consultation with the patient  
86 determines that a shorter period of hospital stay is appropriate;

87 14. A requirement that certificates of medical necessity for durable medical equipment and any  
88 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician  
89 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60  
90 days from the time the ordered durable medical equipment and supplies are first furnished by the  
91 durable medical equipment provider;

92 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons  
93 age 40 and over who are at high risk for prostate cancer, according to the most recent published  
94 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal  
95 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this  
96 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate  
97 specific antigen;

98 16. A provision for payment of medical assistance for low-dose screening mammograms for  
99 determining the presence of occult breast cancer. Such coverage shall make available one screening  
100 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through  
101 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an  
102 X-ray examination of the breast using equipment dedicated specifically for mammography, including but  
103 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average  
104 radiation exposure of less than one rad mid-breast, two views of each breast;

105 17. A provision, when in compliance with federal law and regulation and approved by the Centers  
106 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to  
107 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid  
108 program and may be provided by school divisions;

109 18. A provision for payment of medical assistance services for liver, heart and lung transplantation  
110 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or  
111 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and  
112 application of the procedure in treatment of the specific condition have been clearly demonstrated to be  
113 medically effective and not experimental or investigational; (iii) prior authorization by the Department of  
114 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific  
115 transplant center where the surgery is proposed to be performed have been used by the transplant team  
116 or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy  
117 has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is  
118 not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and  
119 restore a range of physical and social functioning in the activities of daily living;

120 19. A provision for payment of medical assistance for colorectal cancer screening, specifically  
121 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in  
122 appropriate circumstances radiologic imaging, in accordance with the most recently published  
123 recommendations established by the American College of Gastroenterology, in consultation with the  
124 American Cancer Society, for the ages, family histories, and frequencies referenced in such  
125 recommendations;

126 20. A provision for payment of medical assistance for custom ocular prostheses;

127 21. A provision for payment for medical assistance for infant hearing screenings and all necessary  
128 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the  
129 United States Food and Drug Administration, and as recommended by the national Joint Committee on  
130 Infant Hearing in its most current position statement addressing early hearing detection and intervention  
131 programs. Such provision shall include payment for medical assistance for follow-up audiological  
132 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and  
133 performed by a licensed audiologist to confirm the existence or absence of hearing loss;

134 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer  
135 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer  
136 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease  
137 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under  
138 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including  
139 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under  
140 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise  
141 eligible for medical assistance services under any mandatory categorically needy eligibility group; and  
142 (v) have not attained age 65. This provision shall include an expedited eligibility determination for such  
143 women;

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

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

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

162 26. *A provision for the payment of medical assistance for health care services provided through*  
163 *telemedicine services, including remote monitoring services, as those terms are defined in §*  
164 *38.2-3418.16, and the use of telemedicine technologies as it pertains to remote patient monitoring*  
165 *services to the full extent that these services are available.*

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

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

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

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

172 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations  
173 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social  
174 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact  
175 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact  
176 analysis shall include the projected costs/savings to the local boards of social services to implement or  
177 comply with such regulation and, where applicable, sources of potential funds to implement or comply  
178 with such regulation.

179 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in  
180 accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities

181 With Deficiencies."

182 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or  
183 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each  
184 recipient of medical assistance services, and shall upon any changes in the required data elements set  
185 forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective  
186 information as may be required to electronically process a prescription claim.

187 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for  
188 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,  
189 regardless of any other provision of this chapter, such amendments to the state plan for medical  
190 assistance services as may be necessary to conform such plan with amendments to the United States  
191 Social Security Act or other relevant federal law and their implementing regulations or constructions of  
192 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health  
193 and Human Services.

194 In the event conforming amendments to the state plan for medical assistance services are adopted, the  
195 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter  
196 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the  
197 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or  
198 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the  
199 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with  
200 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular  
201 session of the General Assembly unless enacted into law.

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

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

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

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

216 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement  
217 or contract, with a provider who is or has been a principal in a professional or other corporation when  
218 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315,  
219 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal  
220 program pursuant to 42 C.F.R. Part 1002.

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

223 6. (Expires January 1, 2020) Provide payments or transfers pursuant to § 457 of the Internal Revenue  
224 Code to the deferred compensation plan described in § 51.1-602 on behalf of an individual who is a  
225 dentist or an oral and maxillofacial surgeon providing services as an independent contractor pursuant to  
226 a Medicaid agreement or contract under this section. Notwithstanding the provisions of § 51.1-600, an  
227 "employee" for purposes of Chapter 6 (§ 51.1-600 et seq.) of Title 51.1 shall include an independent  
228 contractor as described in this subdivision.

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

230 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider  
231 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R.  
232 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative  
233 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of  
234 the date of receipt of the notice.

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

241 F. When the services provided for by such plan are services which a marriage and family therapist,  
242 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed

243 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,  
244 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or  
245 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter  
246 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations  
247 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical  
248 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based  
249 upon reasonable criteria, including the professional credentials required for licensure.

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

255 H. The Department of Medical Assistance Services shall:

256 1. Include in its provider networks and all of its health maintenance organization contracts a  
257 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have  
258 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse  
259 and neglect, for medically necessary assessment and treatment services, when such services are delivered  
260 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a  
261 provider with comparable expertise, as determined by the Director.

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

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

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

273 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public  
274 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by  
275 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law  
276 and regulation.

277 **§ 38.2-3418.16. Coverage for telemedicine services.**

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

284 B. As used in this section, "~~telemedicine services~~,":

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

290 "*Telemedicine services*" as it pertains to the delivery of health care services, means the use of  
291 electronic technology or media, including interactive audio or video, for the purpose of diagnosing or  
292 treating a patient, *providing remote patient monitoring services*, or consulting with other health care  
293 providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an  
294 audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

295 C. An insurer, corporation, or health maintenance organization shall not exclude a service for  
296 coverage solely because the service is provided through telemedicine services and is not provided  
297 through face-to-face consultation or contact between a health care provider and a patient for services  
298 appropriately provided through telemedicine services.

299 D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the  
300 treating provider or the consulting provider for technical fees or costs for the provision of telemedicine  
301 services; however, such insurer, corporation, or health maintenance organization shall reimburse the  
302 treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured  
303 delivered through telemedicine services on the same basis that the insurer, corporation, or health

304 maintenance organization is responsible for coverage for the provision of the same service through  
305 face-to-face consultation or contact.

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

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

316 G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime  
317 dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum  
318 that applies in the aggregate to all items and services covered under the policy, or impose upon any  
319 person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or  
320 any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits  
321 or services, that is not equally imposed upon all terms and services covered under the policy, contract,  
322 or plan.

323 H. The requirements of this section shall apply to all insurance policies, contracts, and plans  
324 delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011,  
325 or at any time thereafter when any term of the policy, contract, or plan is changed or any premium  
326 adjustment is made.

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

331 *J. The coverage required by this section shall include the use of telemedicine technologies as it*  
332 *pertains to remote patient monitoring services to the full extent that these services are available.*

333 **§ 54.1-2901. Exceptions and exemptions generally.**

334 A. The provisions of this chapter shall not prevent or prohibit:

335 1. Any person entitled to practice his profession under any prior law on June 24, 1944, from  
336 continuing such practice within the scope of the definition of his particular school of practice;

337 2. Any person licensed to practice naturopathy prior to June 30, 1980, from continuing such practice  
338 in accordance with regulations promulgated by the Board;

339 3. Any licensed nurse practitioner from rendering care in accordance with the provisions of  
340 §§ 54.1-2957 and 54.1-2957.01 or any nurse practitioner licensed by the Boards of Medicine and  
341 Nursing in the category of certified nurse midwife practicing pursuant to subsection H of § 54.1-2957  
342 when such services are authorized by regulations promulgated jointly by the Boards of Medicine and  
343 Nursing;

344 4. Any registered professional nurse, licensed nurse practitioner, graduate laboratory technician or  
345 other technical personnel who have been properly trained from rendering care or services within the  
346 scope of their usual professional activities which shall include the taking of blood, the giving of  
347 intravenous infusions and intravenous injections, and the insertion of tubes when performed under the  
348 orders of a person licensed to practice medicine or osteopathy, a nurse practitioner, or a physician  
349 assistant;

350 5. Any dentist, pharmacist or optometrist from rendering care or services within the scope of his  
351 usual professional activities;

352 6. Any practitioner licensed or certified by the Board from delegating to personnel supervised by  
353 him, such activities or functions as are nondiscretionary and do not require the exercise of professional  
354 judgment for their performance and which are usually or customarily delegated to such persons by  
355 practitioners of the healing arts, if such activities or functions are authorized by and performed for such  
356 practitioners of the healing arts and responsibility for such activities or functions is assumed by such  
357 practitioners of the healing arts;

358 7. The rendering of medical advice or information through telecommunications from a physician  
359 licensed to practice medicine in Virginia or an adjoining state, or from a licensed nurse practitioner, to  
360 emergency medical personnel acting in an emergency situation;

361 8. The domestic administration of family remedies;

362 9. The giving or use of massages, steam baths, dry heat rooms, infrared heat or ultraviolet lamps in  
363 public or private health clubs and spas;

364 10. The manufacture or sale of proprietary medicines in this Commonwealth by licensed pharmacists  
365 or druggists;

- 366 11. The advertising or sale of commercial appliances or remedies;
- 367 12. The fitting by nonitinerant persons or manufacturers of artificial eyes, limbs or other apparatus or
- 368 appliances or the fitting of plaster cast counterparts of deformed portions of the body by a nonitinerant
- 369 bracer or prosthetist for the purpose of having a three-dimensional record of the deformity, when
- 370 such bracer or prosthetist has received a prescription from a licensed physician, licensed nurse
- 371 practitioner, or licensed physician assistant directing the fitting of such casts and such activities are
- 372 conducted in conformity with the laws of Virginia;
- 373 13. Any person from the rendering of first aid or medical assistance in an emergency in the absence
- 374 of a person licensed to practice medicine or osteopathy under the provisions of this chapter;
- 375 14. The practice of the religious tenets of any church in the ministration to the sick and suffering by
- 376 mental or spiritual means without the use of any drug or material remedy, whether gratuitously or for
- 377 compensation;
- 378 15. Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally
- 379 licensed practitioners in this Commonwealth;
- 380 16. Any practitioner of the healing arts licensed or certified and in good standing with the applicable
- 381 regulatory agency in another state or Canada when that practitioner of the healing arts is in Virginia
- 382 temporarily and such practitioner has been issued a temporary authorization by the Board from
- 383 practicing medicine or the duties of the profession for which he is licensed or certified (i) in a summer
- 384 camp or in conjunction with patients who are participating in recreational activities, (ii) while
- 385 participating in continuing educational programs prescribed by the Board, or (iii) by rendering at any
- 386 site any health care services within the limits of his license, voluntarily and without compensation, to
- 387 any patient of any clinic which is organized in whole or in part for the delivery of health care services
- 388 without charge as provided in § 54.1-106;
- 389 17. The performance of the duties of any active duty health care provider in active service in the
- 390 army, navy, coast guard, marine corps, air force, or public health service of the United States at any
- 391 public or private health care facility while such individual is so commissioned or serving and in
- 392 accordance with his official military duties;
- 393 18. Any masseur, who publicly represents himself as such, from performing services within the scope
- 394 of his usual professional activities and in conformance with state law;
- 395 19. Any person from performing services in the lawful conduct of his particular profession or
- 396 business under state law;
- 397 20. Any person from rendering emergency care pursuant to the provisions of § 8.01-225;
- 398 21. Qualified emergency medical services personnel, when acting within the scope of their
- 399 certification, and licensed health care practitioners, when acting within their scope of practice, from
- 400 following Durable Do Not Resuscitate Orders issued in accordance with § 54.1-2987.1 and Board of
- 401 Health regulations, or licensed health care practitioners from following any other written order of a
- 402 physician not to resuscitate a patient in the event of cardiac or respiratory arrest;
- 403 22. Any commissioned or contract medical officer of the army, navy, coast guard or air force
- 404 rendering services voluntarily and without compensation while deemed to be licensed pursuant to
- 405 § 54.1-106;
- 406 23. Any provider of a chemical dependency treatment program who is certified as an "acupuncture
- 407 detoxification specialist" by the National Acupuncture Detoxification Association or an equivalent
- 408 certifying body, from administering auricular acupuncture treatment under the appropriate supervision of
- 409 a National Acupuncture Detoxification Association certified licensed physician or licensed acupuncturist;
- 410 24. Any employee of any assisted living facility who is certified in cardiopulmonary resuscitation
- 411 (CPR) acting in compliance with the patient's individualized service plan and with the written order of
- 412 the attending physician not to resuscitate a patient in the event of cardiac or respiratory arrest;
- 413 25. Any person working as a health assistant under the direction of a licensed medical or osteopathic
- 414 doctor within the Department of Corrections, the Department of Juvenile Justice or local correctional
- 415 facilities;
- 416 26. Any employee of a school board, authorized by a prescriber and trained in the administration of
- 417 insulin and glucagon, when, upon the authorization of a prescriber and the written request of the parents
- 418 as defined in § 22.1-1, assisting with the administration of insulin or administering glucagon to a
- 419 student diagnosed as having diabetes and who requires insulin injections during the school day or for
- 420 whom glucagon has been prescribed for the emergency treatment of hypoglycemia;
- 421 27. Any practitioner of the healing arts or other profession regulated by the Board from rendering
- 422 free health care to an underserved population of Virginia who (i) does not regularly practice his
- 423 profession in Virginia, (ii) holds a current valid license or certificate to practice his profession in another
- 424 state, territory, district or possession of the United States, (iii) volunteers to provide free health care to
- 425 an underserved area of the Commonwealth under the auspices of a publicly supported all volunteer,
- 426 nonprofit organization that sponsors the provision of health care to populations of underserved people,

427 (iv) files a copy of the license or certification issued in such other jurisdiction with the Board, (v)  
428 notifies the Board at least five business days prior to the voluntary provision of services of the dates and  
429 location of such service, and (vi) acknowledges, in writing, that such licensure exemption shall only be  
430 valid, in compliance with the Board's regulations, during the limited period that such free health care is  
431 made available through the volunteer, nonprofit organization on the dates and at the location filed with  
432 the Board. The Board may deny the right to practice in Virginia to any practitioner of the healing arts  
433 whose license or certificate has been previously suspended or revoked, who has been convicted of a  
434 felony or who is otherwise found to be in violation of applicable laws or regulations. However, the  
435 Board shall allow a practitioner of the healing arts who meets the above criteria to provide volunteer  
436 services without prior notice for a period of up to three days, provided the nonprofit organization  
437 verifies that the practitioner has a valid, unrestricted license in another state;

438 28. Any registered nurse, acting as an agent of the Department of Health, from obtaining specimens  
439 of sputum or other bodily fluid from persons in whom the diagnosis of active tuberculosis disease, as  
440 defined in § 32.1-49.1, is suspected and submitting orders for testing of such specimens to the Division  
441 of Consolidated Laboratories or other public health laboratories, designated by the State Health  
442 Commissioner, for the purpose of determining the presence or absence of tubercle bacilli as defined in  
443 § 32.1-49.1;

444 29. Any physician of medicine or osteopathy or nurse practitioner from delegating to a registered  
445 nurse under his supervision the screening and testing of children for elevated blood-lead levels when  
446 such testing is conducted (i) in accordance with a written protocol between the physician or nurse  
447 practitioner and the registered nurse and (ii) in compliance with the Board of Health's regulations  
448 promulgated pursuant to §§ 32.1-46.1 and 32.1-46.2. Any follow-up testing or treatment shall be  
449 conducted at the direction of a physician or nurse practitioner;

450 30. Any practitioner of one of the professions regulated by the Board of Medicine who is in good  
451 standing with the applicable regulatory agency in another state or Canada from engaging in the practice  
452 of that profession when the practitioner is in Virginia temporarily with an out-of-state athletic team or  
453 athlete for the duration of the athletic tournament, game, or event in which the team or athlete is  
454 competing;

455 31. Any person from performing state or federally funded health care tasks directed by the consumer,  
456 which are typically self-performed, for an individual who lives in a private residence and who, by  
457 reason of disability, is unable to perform such tasks but who is capable of directing the appropriate  
458 performance of such tasks; or

459 32. Any practitioner of one of the professions regulated by the Board of Medicine who is in good  
460 standing with the applicable regulatory agency in another state from engaging in the practice of that  
461 profession in Virginia with a patient who is being transported to or from a Virginia hospital for care.

462 33. *Any practitioner of one of the professions regulated by the Board of Medicine who is located in*  
463 *another state and is in good standing with the applicable regulatory agency in such state from providing*  
464 *telemedicine services within the scope of his practice, as defined in § 38.2-3418.16, to a patient located*  
465 *in Virginia.*

466 B. Notwithstanding any provision of law or regulation to the contrary, military medical personnel, as  
467 defined in § 2.2-2001.4, while participating in a program established by the Department of Veterans  
468 Services pursuant to § 2.2-2001.4, may practice under the supervision of a licensed physician or  
469 podiatrist or the chief medical officer of an organization participating in such program, or his designee  
470 who is a licensee of the Board and supervising within his scope of practice.

471 **§ 54.1-2903. What constitutes practice; location of practice.**

472 A. Any person shall be regarded as practicing the healing arts who actually engages in such practice  
473 as defined in this chapter, or who opens an office for such purpose, or who advertises or announces to  
474 the public in any manner a readiness to practice or who uses in connection with his name the words or  
475 letters "Doctor," "Dr.," "M.D.," "D.O.," "D.P.M.," "D.C.," "Healer," "N.P.," or any other title, word,  
476 letter or designation intending to designate or imply that he is a practitioner of the healing arts or that  
477 he is able to heal, cure or relieve those suffering from any injury, deformity or disease. No person  
478 regulated under this chapter shall use the title "Doctor" or the abbreviation "Dr." in writing or in  
479 advertising in connection with his practice unless he simultaneously uses a clarifying title, initials,  
480 abbreviation or designation or language that identifies the type of practice for which he is licensed.

481 B. Signing a birth or death certificate, or signing any statement certifying that the person so signing  
482 has rendered professional service to the sick or injured, or signing or issuing a prescription for drugs or  
483 other remedial agents, shall be prima facie evidence that the person signing or issuing such writing is  
484 practicing the healing arts within the meaning of this chapter except where persons other than physicians  
485 are required to sign birth certificates.

486 C. *In cases in which a practitioner of the healing arts is providing telemedicine services, such*  
487 *practice is deemed to occur where the practitioner is located at the time of provision.*