

Reimbursement for Disaster Virtual Care Providers

Disclaimer: This material is for **informational purposes only** to support disaster virtual care planning and operations. It **does not constitute legal advice** and should not be relied upon as a substitute for consultation with qualified counsel. Laws, waivers, and declarations **change rapidly**; clinicians and organizations should verify current requirements with their state authorities, payors, and legal advisors. Providers should verify current requirements with their **state licensing boards, activating entities, and legal counsel** before providing care.

Cross-State Billing and Jurisdiction

Reimbursement follows the **patient's location**, not the provider's¹³. Medicare and Medicaid may pay for cross-state virtual care if authorized under federal waiver rules, but private payors aren't required to unless state law compels it²². Licensure compacts or waivers allow legal practice but don't guarantee payment^{13,14}.

Some payors require special modifiers to flag disaster claims^{4,24}. Incorrect coding or missing modifiers can trigger automatic denials. Always verify the payor's requirements for cross-state virtual care before submitting claims.

How Payment Rules Change in Disasters

During federally declared emergencies, **CMS 1135 waivers** can temporarily relax billing rules for Medicare and Medicaid^{1,2}. These waivers remove geographic and originating-site restrictions, permit virtual care billing parity, and allow audio-only encounters for certain codes^{3,6}. However, they don't automatically extend to private payors unless state law requires it¹⁴. Medicare virtual care coverage at in-person rates continues only while the federal declaration or congressional extensions remain active¹¹. Medicaid programs can mirror these changes through state plan amendments or emergency orders, but coverage, rate parity, and modality rules differ widely by state¹⁵. Private insurers may follow federal flexibilities voluntarily or as required by state insurance law^{13,22}. Always verify which waivers are still active before billing.

If a Claim Is Denied or Audited

If a claim is denied, the billing **entity**, not the individual clinician, is responsible for responding, appealing, or refunding overpayments^{4,7}. Disaster billing is typically submitted under an organization's NPI, so the employer or activating entity owns the financial risk. Still, clinicians must maintain their own documentation and alert their organization immediately if an audit notice arrives¹⁶. Claims can be denied retroactively if payor waivers expired or if a provider's licensure authority wasn't valid on the date of service^{13,22}. Keeping copies of activation orders and licensure verifications helps prove the service was lawful and reimbursable.

Who Pays for Virtual Care Costs

Operational costs, like platforms, internet access, interpreters, or administrative support, are generally the responsibility of the activating entity, not individual clinicians⁷. ESF-8, EMAC, and hospital deployments can potentially recover these expenses through **FEMA PA**, ASPR's **Hospital Preparedness Program**, or **HRSA grants**⁸⁻¹⁰. These funding streams reimburse infrastructure and support expenses, not clinician wages, unless specified in a contract. FEMA and HRSA require detailed activation records, invoices, and cost documentation for reimbursement¹⁷. Keep receipts and deployment records from the start; those same records protect you legally and financially.

Documentation & Audit Readiness

Even in an emergency, documentation standards don't disappear. Each virtual care record should include the patient's **location, consent, modality** (audio/video), **diagnosis**, and **provider credentials**^{3,4}. If a disaster-specific waiver was used, keep proof of eligibility^{1,2}. Some organizations also require encounters to be marked as disaster-related, such as noting the declaration ID or operational period. While not universally required, this helps distinguish disaster care from routine telehealth and supports FEMA, CMS, and HRSA audit reviews. Entities billing FEMA, HRSA, or CMS must retain both care and financial documentation for three to seven years, depending on the funding source^{7,17}. Missing records are the most common reason FEMA or CMS audits demand repayment¹⁶. Always document as if you expect an audit; the same paperwork supports both your reimbursement and your immunity.

When Flexibilities End

Medicare flexibilities tied to 1135 waivers expire when the federal Public Health Emergency or Stafford Act declaration ends, unless extended by Congress or rulemaking^{1,11}. However, 1135 waivers are time-limited and may expire, be amended, or be reauthorized during an ongoing disaster. Providers should monitor active waiver periods and any CMS updates throughout the event, not only at the end of the declaration. State Medicaid and private-payor timelines vary. Some terminate immediately, while others extend temporarily through state-level emergency orders^{14,15}. Private payors may revert to pre-disaster policies as soon as the federal waiver ends unless state law mandates continued parity²². Providers should track three timelines: the federal waiver end date, the state emergency expiration, and each payor's policy update. They should also track 1135 waiver extensions and expirations to ensure claims are billed only under active flexibilities. Continuing to bill under expired flexibilities can lead to claim denials or recoupment.



Volunteer or Paid: How Status Affects Immunity and Billing

Whether a clinician is classified as a **volunteer** or a **paid provider** determines both malpractice immunity and billing rights. Most state volunteer protection laws allow reimbursement for expenses like travel, meals, or virtual care platform costs without affecting immunity. But once a provider receives direct payment, such as a stipend or per diem, they're typically reclassified as compensated, which can cancel volunteer immunity^{1,2}.

Federal and state relief programs usually reimburse the **organization**, not the individual. FEMA's Public Assistance (PA) program covers costs like staffing or supplies but does not pay providers for their time⁷. HRSA grants can fund virtual care staffing or infrastructure, but clinicians are only considered paid if formally listed as staff or contractors^{9,10}. Before deployment, clarify whether you'll be unpaid, expense-reimbursed, or compensated, since that status determines both your immunity and billing authority¹⁹.

In practice, whether you're classified as a volunteer or a paid responder changes what protections and billing rules apply. The following **Volunteer vs. Paid Table** summarizes how those differences play out during a disaster deployment.

Volunteer vs. Paid Table

Volunteer	Paid
Immunity under Volunteer Protection/State Laws may apply.	Standard malpractice coverage applies.
No billing to patients or payors.	Eligible to bill under CMS 1135 and payor waivers.
May qualify for FEMA/HRSA relief funding.	Maintain: patient location, time, diagnosis, declaration ID.
Keep log of time, services, & expenses (for later reporting)	Private payor rules may differ, verify each plan.
Still document consent and patient location.	Payment ≠ immunity

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