OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Frequently Asked Questions: COVID-19 Testing

July 20, 2020

(NOTE: Additional FAQ's may be issued as more information is available)

The Office of the Insurance Commissioner (OIC) is providing guidance to health carriers related to implementation of §6001 of the Families First Coronavirus Response Act (FFCRA), as amended by §3201 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and §3202 of the CARES Act related to COVID-19 testing. This guidance is informed by tri-agency guidance issued by the Department of Health and Human Services, the Department of Labor and Treasury on April 11, 2020 and June 23, 2020.[1]

1. **Question**: Are both the federal FFCRA and CARES Act testing provisions and the OIC emergency orders and FAQ's issued during the COVID-19 emergency related to COVID-19 testing in effect?

   Response: Yes. While the governor's COVID-19 emergency declaration has been in effect, Commissioner Kreidler has issued emergency orders and frequently asked questions (FAQ's) related to COVID-19 testing under the authority granted in RCW 48.02.060.[2] The emergency orders have been extended for additional 30-day periods, with the exception of the grace period provision of Emergency Order 20-02.

   Several provisions of the OIC orders address coverage of COVID-19 testing. The OIC also has issued FAQs that further explain and interpret the OIC's orders. Where the COVID testing provisions of FFCRA and the CARES Act are broader than those in OIC's orders, the federal

[1] *FAQ's About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42* (April 11, 2020) accessed at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf; *FAQ's About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43* (June 23, 2020) accessed at https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf.

[2] Office of the Insurance Commissioner, Emergency Order 20-01 (March 5, 2020), accessed at https://www.insurance.wa.gov/sites/default/files/documents/emergency-order-number-20-01.pdf; Office of the Insurance Commissioner, Emergency Order 20-02 (March 24, 2020), accessed at https://www.insurance.wa.gov/sites/default/files/documents/emergency-order-20-02_3.pdf; Office of the Insurance Commissioner, Frequently Asked Questions: OIC Emergency Orders 20-01 and 20-02 and other COVID-19 Related Issues (April 7, 2020), accessed at https://www.insurance.wa.gov/sites/default/files/documents/frequently-asked-questions-about-Emergency-Order-2020-1-and-2_0.pdf.

standard applies. Where OIC's orders provide greater coverage than that required under federal law, the commissioner's orders and state law are the applicable standard. As discussed in previous FAQs, Directive B of Emergency Order 20-02 requires carriers to cover prior to application of any deductible and without cost sharing, diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), when any of this testing is determined medically necessary by the enrollee's health care provider, and when billed in conjunction with a COVID-19 related diagnosis code. While the FFCRA and CARES Act provisions require coverage of this testing without cost-sharing only if a COVID-19 test is ordered, the OIC emergency order does not condition such coverage on a provider's ordering a COVID-19 test.

2. **Question:** Can a carrier deny or otherwise apply medical necessity or other medical management criteria to COVID-19 testing, including antibody testing, when the testing has been determined to be medically appropriate for an individual, as determined by an attending health care provider in accordance with current accepted standards of medical practice?

   Response: No. The tri-agency guidance clarifies that antibody testing can be used for diagnostic purposes and that the decision as to which diagnostic test is appropriate for an individual enrollee is based on an individualized determination of an attending provider.[3] A carrier cannot substitute its medical judgment for the attending provider's decision to order or administer a diagnostic test – deference must be given to the judgement of the attending provider. As Question 6 of the June 23 tri-agency guidance notes, although health plan issuers may not impose prior authorization or other medical management requirements to deny coverage for individuals who are tested multiple times, providers are urged to consult guidance issued by the CDC, as well as state, tribal, territorial, and local health departments or professional societies, when determining whether diagnostic testing is appropriate for a particular individual.

3. **Question:** Does "medical management" include prior authorization requirements, medical necessity review or quantity limits on testing?

   Response: Yes. These activities are considered "medical management."

4. **Question:** Would COVID-19 testing ordered by a provider who is employed by a local public health agency or a long term care facility who makes an individualized clinical assessment of a person to determine whether the test is medically necessary for the individual in accordance with current accepted standards of medical practice be within the scope of §6001 of FFCRA, and §3201and §3202 of the CARES Act?

   Response: Yes. Question 3 of the June 23 tri-agency guidance defines an "attending provider" as an individual who is licensed (or otherwise authorized) under applicable law, who is acting within the scope of the provider's license (or authorization), is acting in accordance with current accepted standards of medical practice, and who is responsible for providing care to the patient. Nothing in that guidance limits the employment status of the provider. The critical factor is that the provider has ordered testing following an individualized assessment of a person, and made a determination that a test is medically necessary. If there are concerns that staff at a public health agency, long-

[3] DOL/HHS/Treasury, FAQ's About Families First Coronavirus Response and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43 (June 23, 2020), accessed at https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf

term care facility, or other facility, are not acting within the scope of their licensure, or are not acting within current accepted medical standards, those issues can be reported to the appropriate provider licensing boards.

5. **Question**: Are carriers required to cover COVID-19 diagnostic testing that has been ordered by an out-of-network (OON) provider when the OON provider orders the test following an individualized assessment of the person?

   Response: Yes, under FFCRA, the CARES Act, and the tri-agency guidance issued to date, the COVID-19 test, as well as related items and services, including the provider visit, during which an individualized assessment occurs and a COVID-19 test is ordered, must be covered when the services are furnished by an OON provider. For "rule out" testing that does not result in the provider ordering a COVID-19 test, which is required only by Emergency Order 20-02, carriers may limit coverage to only in-network providers.

6. **Question**: Does the Balance Billing Protection Act (BBPA) apply to payments for OON laboratory services for COVID-19 testing?

   Response: Yes, if the claims arise either through the provision of emergency medical services or the provision of non-emergency services at an in-network hospital or ambulatory surgical facility. The BBPA's RCW 48.49.020 to .040 and OIC rules implementing those provisions govern the determination of rates paid for OON COVID-19 testing claims that are subject to the BBPA.

   For all other circumstances, §3202 of the CARES Act, and Question 10 of the June 23 tri-agency guidance provide that, if a plan or issuer does not have a negotiated rate with a provider of COVID-19 diagnostic testing, the plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website or the plan or issuer may negotiate a rate with the provider that is lower than the cash price.[4] Providers that fail to publish their cash price may be subject to sanctions imposed by the federal government.

[4] DOL/HHS/Treasury, FAQ's About Families First Coronavirus Response and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43 (June 23, 2020), accessed at https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf