

Frequently Asked Questions: OIC Emergency Orders 20-01 and 20-02 and other COVID-19 related issues

April 7, 2020

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

Questions related to Emergency Order 20-02

Directive A: Telemedicine

- 1. Question:** Will OIC be exercising its enforcement discretion to withhold enforcement of violations of the 30 day prompt pay rule for carrier adjudication of telehealth claims to ensure that they are paid at parity with in-person visits?

Response: Yes, until April 25, 2020, the OIC will presume that good cause exists for carriers that fail to process telemedicine claims within the timeframes outlined in WAC 284-170-431(2) as long as 95% of all clean telemedicine claims are paid within 45 days of receipt by the responsible carrier or agent of the carrier.

WAC 284-43-431(7) provides that providers, facilities, and carriers are not required to comply with the requirement to pay 95% of all clean claims within 30 days of receipt and 95% of all claims, clean or not, within 60 days of receipt, if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

Governor Inslee's Proclamation 20-29 regarding telemedicine payment parity was issued on March 25 and was effective immediately. For the initial thirty day period that Proclamation 20-29 is in effect, until April 25, 2020, exclusively for purposes of payment of telemedicine claims in compliance with Proclamation 20-29, OIC will presume that a failure to comply with the timeframes in WAC 284-170-431(2)(a)(i-ii) is caused by an act of a governmental authority responding to an emergency under WAC 284-170-431(7). This timeframe may be extended if Proclamation 20-09 is extended.

- 2. Question:** Are all audio-only telemedicine encounters still subject to the terms and conditions of the plan, including utilization review and maintaining standards of care?

Response: Yes. Directive A. of OIC Emergency Order 20-02 expands the use of telemedicine services as an alternative to in-person visits during the period of the COVID-19 emergency. RCW 48.43.735(6) provides that a health carrier may subject coverage of a telemedicine or store and forward technology health service under RCW 48.43.735(1) to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

3. **Question:** Will OIC require that carriers follow Medicare payment provisions for telemedicine services where rates differ between office versus facility?

Response: OIC generally does not regulate payment or billing methodologies. Carriers have the option to negotiate and determine the telemedicine payment methodology they will use to comply with Proclamation 20-29 with the providers in their network. Proclamation 20-29 prohibits carriers "from reimbursing in-network providers for telemedicine claims for medically necessary covered services at a rate lower than the contracted rate that would be paid if the services had been delivered through traditional (in-person) methods".

4. **Question:** Will OIC allow carriers to define clinical appropriateness parameters for use of telehealth and define which services can be delivered via telehealth?

Response: Yes, the OIC will allow carriers to implement parameters for the clinical appropriateness of telemedicine to the extent such parameters do not conflict with the telemedicine provisions of OIC Emergency Order 20-02 and Governor Inslee's Proclamation 20-29. In addition to the requirements already contained in RCW 48.43.735, the OIC expects any telemedicine clinical appropriateness parameters to comply with the following:

- Carriers are not required to cover services via telemedicine unless such services are covered under the carrier's health benefit plans. RCW 48.43.735, as modified by Proclamation 20-29 and OIC Emergency Order 20-02, governs the circumstances under which telemedicine services must be covered.
- Per Proclamation 20-29 and RCW 48.43.735, carrier adopted parameters concerning telemedicine must permit all categories of in-network providers to deliver clinically appropriate, medically necessary covered health services within their scope of practice via telemedicine to covered enrollees. This includes types of providers that have not traditionally been included in carrier telemedicine parameters, such as providers offering occupational therapy, physical therapy, and speech and language pathology.
- Carrier determinations of the clinical appropriateness of telemedicine services must take into consideration all relevant factors relating to the immediate and critical need to fight the spread of COVID-19, including but not limited to protecting providers and patients from infection risks and ensuring adequate access and continuity of care.
- Carriers shall not create or enforce any telemedicine coverage requirements or limitations with respect to the originating site for telemedicine services that are inconsistent with RCW 48.43.735(3).
- Carriers may establish reasonable parameters for clinically appropriate telemedicine services, but those parameters may not impose any specific requirements on the types of technologies used to deliver telemedicine services (including any limitations on audio-

only or live video technologies), except that carriers may deem some services not clinically appropriate to deliver through means of an audio-only system.

- The existence of clinical appropriateness parameters will not shield carriers from potential legal action if the OIC determines such parameters create a barrier to services mandated under RCW 48.43.735, Proclamation 20-29 or OIC Emergency Order 20-02.

Directive B: Coverage of diagnostic test panels

- 1. Question:** Do requirements in Directive B. of OIC Emergency Order 20-02 to cover diagnostic panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) without cost-sharing or applying a deductible put high deductible health plans with qualifying HSA's at risk?

Response: Probably not, but the OIC is seeking clarification from the IRS. IRS Notice 2020-15 related to HDHP's and COVID-19 provides as follows: "... (A) health plan that otherwise satisfies the requirements to be an HDHP under section 223(c)(2)(A) will not fail to be an HDHP merely because the health plan provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible." The OIC believes additional diagnostic panels associated with a COVID-19 test are included in the "medical care services" related to COVID-19 testing that are already covered by the IRS's previous guidance. The OIC will attempt to obtain clarification from the IRS regarding its interpretation of this language. In the interim, a carrier must establish the plan's cost sharing for the coverage of the diagnostic panels in Directive B. of OIC Emergency Order 20-02 at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions from his or her HDHP with a qualifying HSA under IRS laws, regulations and notices.

- 2. Question:** With respect to Directive B. of OIC Emergency Order 20-02, are health plans only supposed to cover the diagnostic test panels at 100% if there is a COVID 19 diagnosis? The order states as such, but the summary eludes to coverage of all the testing if they are provided with the COVID 19 test (in the same visit and claim). Is it the specific COVID 19 diagnosis code or the code for the COVID 19 specific test that pulls in the claim to pay at 100%?

Response: No, coverage of the COVID-19 test, diagnostic test panels and the provider visit at 100% are not dependent upon there being a positive test result for COVID-19 or the diagnostic test panel if the enrollee meets the CDC criteria for COVID-19 testing and their health care provider determines that such testing is medically necessary. Consumers who seek testing in good faith should not be penalized if they have a negative test result. Directive B. of OIC Emergency Order 20-02 is an extension of the consumer protections included in Directive A. of Emergency Order 20-01. Directive A. of Emergency Order 20-01 requires carriers to "cover, prior to application of any deductible and with no cost-sharing, the health care provider visit and ...COVID-19 testing for enrollees who meet the CDC criteria for testing, as determined by the enrollee's health care provider." (See <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>)

Directive D: Prior authorization related to hospital discharge

- 1. Question:** What is meant by “insufficient time” in Directive D. of OIC Emergency Order 20-02?

Response: This will be a fact-specific and case-by-case determination. The language of Directive D. is drawn from existing OIC rules that were adopted in June 2017 and effective January 1, 2018. Subsection (5) of WAC 284-43-2060 provides that carriers must treat as an extenuating circumstance, i.e. eliminate any requirement for prior authorization, situations in which “an enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to delivery of the service”. Given limited hospital bed capacity in our state and the expectation that a significant number of individuals diagnosed with COVID-19 will need acute care that requires hospitalization, OIC anticipates that discharges may need to occur within a period of a day or less. It is OIC’s expectation, that in light of the COVID-19 pandemic, carriers will take all actions within their power necessary to facilitate discharge and transfer so that hospital beds are available for those that need them most.

Directive E: Grace period

- 1. Question:** With respect to claims that are pended during a grace period, how will OIC apply the prompt payment requirements of WAC 284-170-431? Will claims received for members within the new grace period be treated as an exception to comply with these requirements while the emergency order is effective?

Response: No, the OIC does not consider claims made during the grace period required under OIC Emergency Order 20-02 to be an exception to WAC 284-170-431. However, under WAC 284-170-431, claims submitted during a grace period are not considered “clean” claims. Therefore, they need not be paid within 30 days. Instead, these claims are subject to the requirement in WAC 284-170-431(2)(a)(ii) that 95% of claims be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

- 2. Question:** Does Directive B. of Emergency Order 20-04 apply to all communications from Regulated Entities to enrollees or the plan sponsor that are sent during the grace period?

Response: Yes, unless the carrier has sent notification to the plan sponsor and each enrollee household that their health plan is in a grace period through premium billing notices, premium delinquency notifications or other similar communication. If such a notice or notices have been sent, then comparable language does not need to be included in communication related to a particular claim, such as an explanation of benefits or a letter stating the results of a prior authorization request.

Other questions and issues

Out-of-state providers

1. **Question:** Can OIC allow carriers to contract with out-of-state providers and can there be any leniency on provider credentialing requirements?

Response: Yes, the OIC will allow carriers to be flexible in their credentialing requirements to include out of state providers who are permitted to practice in Washington State consistent with the rules and standards established by the Department of Health. WAC 284-170-411 provides that issuer standards for selecting participating providers “must be consistent with rules or standards established by the state department of health or other regulatory authority established in Title 18 RCW for health care providers specified in RCW 18.130.040.”

The Washington State Department of Health has invoked the Uniform Emergency Volunteer Health Practitioner Act, chapter 70.15 RCW, allowing out of state providers to practice in Washington state during an emergency if they are registered with the Department of Health, are licensed in another state and in good standing in every state, and meet certain requirements. Such providers can be compensated or not (see RCW 70.15.010(16)). The OIC will allow carriers to contract with health care providers who are not licensed in Washington state, but who are authorized by DOH to practice in Washington state under chapter 70.15 RCW. OIC encourages carriers to use single case agreements or other payment arrangements to enable such providers to be compensated for their work.

Prior authorization for COVID-19 testing or treatment:

1. **Question:** Directive C. of Emergency Order 20-01 requires carriers to suspend any prior authorization requirements that apply to covered diagnostic testing and treatment of coronavirus disease 2019 (COVID-19). Given the increase in hydroxychloroquine and chloroquine prescribing, and concerns about access to those medications for individuals with conditions such as lupus and rheumatoid arthritis, can carriers place quantity limitations on prescriptions for these medications?

Response: Yes, to preserve access to needed medication, and consistent with the March 2020 Washington State Medical Commission Statement on Chloroquine (<https://wmc.wa.gov/news/wmc%C2%A0statement-chloroquine>), OIC interprets the suspension of prior authorization requirements for testing or treatment of COVID-19 in OIC Emergency Order 20-01 to allow appropriate quantity prescribing limitations on drugs, whether on-label or off-label, if such limitations are consistent with what would be prescribed as a month’s supply of the medication for standard medical indications. This response is intended to allow prescribing limitations, but also ensure that the amount prescribed is at least sufficient for a month’s supply of the medication. It also would not allow for the imposition of clinical prior authorization requirements due to the COVID-19 test’s sometimes limited sensitivity and highly variable availability based on location.

Other

- 1. Question:** Can an employer who offers a fully-insured health plan to their employees continue to offer coverage after an employee's hours have been reduced, if the employee can't come to work, if the employee has been laid-off, or in other circumstances?

Response: The answer depends on what is included in the "participation" language in the insurance contract between the health insurance carrier and the employer. Whether an employee is eligible for health insurance coverage depends on whether the employee's status is included in the "participation" language of the health plan contract. Participation language can include a variety of employee statuses, including the status of former employees.

OIC will allow health plan issuers to endorse group health plans to expand current participation language. Such endorsements will be considered "file and use" and will be effective upon the filing date. Participation language will still be reviewed for compliance with HIPAA's non-discrimination requirements, and must be administered in a non-discriminatory manner.

There may be additional federal laws that impact how employers administer their health plans. If carriers or employers are finding specific state or federal statutes are serving as a barrier to coverage, please let us know, so we can try to work with other state and federal regulators to address those concerns.