

Frequently Asked Questions: COVID-19 testing

In 2020, the Office of the Insurance Commissioner issued three sets of Frequently Asked Questions related to access to and payment for COVID-19 testing. This document includes the three sets of Frequently Asked Questions issued by OIC on this subject, beginning with the most recent.

The Frequently Asked Questions provide additional guidance related to:

- [Office of the Insurance Commissioner Emergency Order No. 20-01](#), originally issued on March 5, 2020 and currently in effect due to extensions of the Order
- [Office of the Insurance Commissioner Order No. 20-02](#), originally issued on March 24, 2020 and currently in effect due to extensions of the Order
- [Office of the Insurance Commissioner Order No. 20-06](#), originally issued on June 1, 2020, and currently in effect due to extensions of the Order
- §6001 of the federal 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

Frequently Asked Questions: COVID-19 Testing (Update #3)

Posted on December 17, 2020

Background

The Office of the Insurance Commissioner (OIC) issued Frequently Asked Questions guidance related to coverage of COVID-19 testing to carriers on July 20, 2020. OIC is providing additional COVID-19 testing 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](#).

Given the surge in cases and broad community spread of COVID-19 in Washington state and greater availability of testing supplies, including new antigen testing, the Washington State Department of Health and Governor Inslee have a goal of increased COVID-19 testing in Washington state. The increased COVID-19 rates in Washington state present great personal risk to Washingtonians and those caring for them, and slows the state's economic recovery.

At present, there are three types of COVID-19 tests:

1. Nucleic Acid Amplification tests, frequently called PCR (Polymerase Chain Reaction) tests, look for the presence of the unique RNA of COVID-19 virus.
2. Antigen tests look for a unique part of COVID-19 virus, such as a specific protein on one of the unique COVID-19 spikes.
3. Antibody tests (also known as serology tests) look for presence of antibodies in a patient's immune system that recognize and may fight off the COVID-19 virus.

While the FFCRA and CARES Act set forth the carrier coverage requirements for all three of the above COVID-19 tests, this FAQ addresses only coverage expectations in the context of COVID-19 PCR and antigen testing that is appropriate to detect or diagnose COVID-19 and which constitute "in-vitro diagnostic tests" described in section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act.

Question: Can a carrier deny or otherwise apply medical necessity or other medical management criteria to COVID-19 testing when the testing has been determined to be medically appropriate for an individual, as determined by an attending provider¹ in accordance with current accepted standards of medical practice, including guidance issued by the Washington State Department of Health (DOH)?

Response: No. The June 23, 2020 tri-agency FFCRA/CARES Act guidance, provides that for the duration of the federal state of emergency, carriers may not impose any medical necessity or other medical

management criteria to COVID-19 testing when the testing has been determined to be medically appropriate for an individual by an attending provider. Similarly, for the duration of Governor Inslee's COVID-19 Emergency Proclamation, carriers must cover PCR and Antigen testing and the administration of such tests without cost-sharing where an attending provider has determined the test is medically appropriate for an enrollee. Providers are expected to act in accordance with accepted standards of medical practice. As noted in the response to Question 6 in the June 23, 2020 tri-agency FFCRA/CARES Act guidance, those standards may include guidance issued by the CDC, as well as state, tribal and local health departments. Therefore, it is appropriate for providers to rely on guidance issued by the DOH when determining whether diagnostic testing is appropriate for a particular individual. 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.

Question: Can a carrier deny or otherwise apply medical necessity or other medical management criteria to COVID-19 testing when an enrollee has been identified as a close contact of a confirmed or clinically diagnosed COVID-19 case by a state, local health jurisdiction or tribal-run contact tracing program, or a health care provider?

Response: No. For the duration of the federal state of emergency, and Governor Inslee's COVID-19 Emergency Proclamation, PCR and Antigen testing and the administration of such tests without cost-sharing must be covered when an attending provider has determined or been informed that an enrollee has been identified as a close contact of a confirmed or clinically diagnosed COVID-19 case by a state, local health jurisdiction or tribal-run contact tracing program, or a health care provider. Identification as a close contact by a state, local health jurisdiction or tribal-run contact tracing program shall be considered a valid basis for a provider to determine that a COVID-19 test is medically appropriate for an individual and constitutes grounds for coverage of COVID-19 testing without cost-sharing, prior authorization or other medical management practices.

Question: Can a carrier deny or otherwise apply medical necessity or other medical management criteria to COVID-19 testing when a COVID-19 diagnostic test is ordered for an enrollee with recent known or suspected exposure to COVID-19?

Response: No. Carriers must cover for the duration of the federal state of emergency, and Governor Inslee's COVID-19 Emergency Proclamation, PCR and Antigen testing and the administration of such tests without cost-sharing when an attending provider has determined the test is medically appropriate for the enrollee in accordance with current accepted standards of medical practice, including guidance issued by DOH. Under current accepted standards of medical practice, including DOH and CDC guidance, "suspected exposure to COVID-19" is not limited to exposure to an identifiable individual suspected of having COVID-19 but may encompass circumstances, the totality of which, cause an attending provider to determine that an individual was recently at reasonable risk of having been exposed to COVID-19.

¹ Question 3 of the [June 23, 2020](#) 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 or requires that a provider have an established relationship with an enrollee.

Question: Can a carrier deny or otherwise apply medical necessity or other medical management criteria to COVID-19 testing when a COVID-19 diagnostic test, or a series of COVID-19 diagnostic tests, ordered for an individual by an attending provider who has determined the test is medically appropriate for that individual may also serve or give the appearance of serving a secondary purpose, such as meeting a workplace health and safety requirement or recommendation.

Response: No. In any case where an attending provider has determined a COVID-19 diagnostic test is medically appropriate for a particular individual, a carrier must consider the test's primary purpose to be the individualized diagnosis or treatment of COVID-19 and provide coverage for the test and the administration of the test without cost-sharing, prior authorization or other medical management practices.

Question: Can a carrier deny or otherwise apply medical necessity or other medical management criteria to COVID-19 testing when an enrollee will be undergoing a clinical or surgical procedure in a hospital or ambulatory surgical facility, where an attending provider has determined that a COVID-19 diagnostic test is medically appropriate for a particular individual?

Response: No. Carriers may not impose any medical necessity or other medical management criteria to COVID-19 testing where an attending provider has determined a COVID-19 diagnostic test is medically appropriate for a particular individual, based on current accepted standards of medical practice, including DOH and CDC guidance.

Frequently Asked Questions: COVID-19 Testing (Update #2)

Posted on 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

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 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.

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->

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.

Question: Does “medical management” include prior authorization requirements, medical necessity review or quantity limits on testing?

Response: Yes. These activities are considered “medical management.”

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 §3201 and §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- 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.

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>

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.

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>

Frequently Asked Questions: COVID-19 Testing (Update #1)

Posted on June 10, 2020

(NOTE: Additional FAQs may be issued as more information is available)

COVID-19 testing performed by reference laboratories:

Question: Are health carriers that offer health plans and short term limited duration medical plans in Washington state required to cover laboratory claims for COVID-19 PCR diagnostic testing that has been authorized pursuant to FDA policy by the FDA or Washington state when an independent clinical laboratory certified under the Clinical Laboratory Improvement Act (CLIA certified) refers a specimen to another CLIA certified laboratory for testing and a modifier 90 is appended to the claim?

Response: Yes. Under OIC Emergency Order 20-01 and §6001(a) of the federal Families First Coronavirus Response Act (FFCRA) and §§3201 & 3202 of the federal CARES Act, carriers are required to cover COVID-19 testing provided by both in-network and out-of-network laboratories without prior authorization or other medical management requirements. The Department of Labor, the Department of Health and Human Services, and the Treasury have issued guidance clarifying that these coverage requirements encompass coverage of COVID-19 PCR diagnostic testing that has been authorized pursuant to FDA policy by the FDA or Washington state when determined medically appropriate for an individual by the individual's attending health care provider in accordance with accepted standards of current medical practice.¹ There is no exception in federal statute, or the tri-agency guidance issued to date, that allows denial of claims submitted by a CLIA-certified independent clinical laboratory (i.e. referring laboratory) that has referred a specimen to another CLIA certified laboratory (i.e. reference laboratory) for testing and appended a modifier 90 to the claim. The federal requirement to pay all medically appropriate COVID-19 testing claims supersedes any internal carrier payment or claims submission policies or guidelines to the contrary.

This FAQ is intended to address only coverage of PCR diagnostic testing when a modifier 90 is appended to the claim. This FAQ is not intended to address coverage of COVID-19 testing that is otherwise covered under OIC Emergency Order 20-01, FFCRA and the CARES Act.

¹ FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42, THE DEPARTMENT OF LABOR, THE DEPARTMENT HEALTH AND HUMAN SERVICES, AND THE TREASURY., at 5-7 (Apr. 11, 2020).