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COVID-19 Testing and Coverage

Frequently Asked Questions (FAQ) #1

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The California Department of Insurance (Department) has received multiple complaints and inquiries pertaining to COVID-19 testing, coverage, and deferred care. The Department reminds consumers and providers that the Department of Insurance is here to help. If you have questions or complaints:

- You can call the Department at **1-800-927-4357 (TTY 800-482-4833)**
- Consumers and providers can submit questions or complaints online at the Department's Consumer and Provider Complaint Center at this link: <http://www.insurance.ca.gov/01-consumers/101-help/>

The Department provides the following information in response to complaints and inquiries received and will update this FAQ periodically.

1. As a consumer, does my health insurer have to waive cost sharing for COVID-19 testing and related diagnostic items and services?

Yes. On March 5, 2020, Insurance Commissioner Ricardo Lara released a *COVID-19 Screening and Testing Bulletin*¹ directing health insurers to waive cost sharing amounts for certain COVID-19 related screening and testing. Since that date, two federal laws were passed, which require coverage for COVID-19 related diagnostic testing and screening, without patient cost sharing, including deductibles, coinsurance, and copays.

Section 6001 of the federal Families First Coronavirus Response Act (FFCRA) (PL 116-127) § 6001, as amended by § 3201 of the federal Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (PL 116-136),² applies to a "group health plan," including insured³ and self-insured group health plans, private employment-based group health plans (ERISA plans), non-federal governmental plans, and church plans.⁴ It also applies to "individual health insurance

¹ California Department of Insurance, COVID-19 Screening and Testing Bulletin (Mar. 5, 2020), available on the Department's website at this link: <http://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/COVID-19-Screening-and-Testing.pdf>.

² See also U.S. Health & Human Services, FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42 (Apr. 11, 2020) (HHS FAQ 42), available at this link: <https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf>; U.S. Health & Human Services, FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43 (June 23, 2020) (HHS FAQ 43), available at this link: <https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf>.

³ 42 USC § 300gg-91(b)(4).

⁴ HHS FAQ 42, Q1; HHS FAQ 43, Q1.

coverage,” which includes coverage offered in the individual market through or outside of Covered California, as well as student health insurance coverage.⁵ These requirements apply to both grandfathered and nongrandfathered coverage.

Coverage of COVID-19 testing and related diagnostic items and services, must be provided without imposing any cost sharing or prior authorization requirements, regardless of network status. But there are some caveats under federal law:

- An attending provider must make an individualized assessment to determine whether the test is medically appropriate.⁶ The federal government broadly defines “attending provider.”
- The related items and services must be furnished during a visit that results in an order for, or administration of, a COVID-19 diagnostic test.
- FFCRA § 6001(a)(2) requires specified items and services, including but not limited to influenza tests and blood tests, to be covered if furnished in-person or during a telehealth visit as well as in a broad range of settings including health care provider offices, urgent care centers, and emergency rooms. The U.S. Department of Health and Human Services specified that this includes “nontraditional” settings such as drive-through testing sites.⁷
- Federal law prohibits “balance billing” for the COVID-19 diagnostic test, but not for related items and services; if the related items and services are provided out-of-network, you may be subject to balance billing.⁸

If your insurer has failed to cover your COVID-19 test, or related items and services, you can file a complaint through the Department’s [Consumer Complaint Center](#) to receive assistance.

2. I’m a provider and insurers have been deducting the cost sharing that must be waived for COVID-19 diagnostic testing and related items and services out of my payments. Can they do this?

No. FFCRA § 6001(a) requires insurers to cover COVID-19 diagnostic testing and related items and services without imposing any cost sharing. This means insurers must cover—i.e., pay for—the waived cost sharing when determining the applicable reimbursement amount for the services insurers must cover under § 6001(a).

Additionally, CARES Act § 3202(a)(1) requires insurers to reimburse COVID-19 diagnostic testing at the negotiated rate for in-network providers, or the provider’s online cash price for providers with whom the insurer does not have a negotiated rate.⁹ Therefore, insurers must pay providers the negotiated rate or online cash price, as applicable, without deducting patient cost sharing, in order to comply with federal law.¹⁰ Providers should contact the Department’s

⁵ FFCRA § 6001, as amended by CARES Act § 3201(d).

⁶ FFCRA § 6001, as amended by CARES Act § 3201.

⁷ HHS FAQ 42, Q8.

⁸ CARES Act § 3202(a) & (b); HHS FAQ 43, Q8 & Q9.

⁹ CARES Act § 3202(a)(1) & (2).

¹⁰ See HHS FAQ 42; HHS FAQ 43, Q7-Q12.

[Provider Complaint Center](#) if a health insurer is not paying the appropriate rate for COVID-19 testing and related items and services as required by federal law.

3. I'm a provider and I'm having a problem with insurers reimbursing, denying or contesting the claim I submitted in a timely manner. Can they do that?

No. Health insurers have a legal obligation to promptly pay claims. Insurance Code §§ 10123.13 and 10123.147 require insurers to pay claims as soon as possible but no later than 30 working days after receipt of a complete claim, unless the insurer notifies the provider in writing that the claim has been denied or is being contested. Insurers must pay interest on a completed claim if the claim has not been reimbursed, contested or denied within the 30 working-day deadline.¹¹ Failure to comply with the claims handling deadlines in state law may also be considered an unfair claims settlement practice under Insurance Code § 790.03(h). Providers should contact the Department's [Provider Complaint Center](#) if a health insurer is not paying claims in compliance with these deadlines.

4. I'm a provider and I am unsure how I should be coding telehealth appointments. Do you have any guidance?

We encourage health insurers to accept coding for telehealth appointments that is consistent with the federal Interim Final Rule issued April 6, 2020 which, in its preamble, notes a revision to the policy regarding office/outpatient evaluation and management (E/M) level selection for services furnished via telehealth. This revised policy provides that the level selection can be based on Medical Decision Making (MDM) factors or time, where time is defined as all of the time associated with the evaluation and management on the day of the encounter. Further, the revised policy removes any requirements regarding documentation of history and/or physical exam in the medical record.¹²

5. As a consumer, I received prior authorization for a procedure that was scheduled, but the procedure was canceled due to a "stay at home" order. Now my prior authorization is set to expire before I can have my procedure. Do I need to receive another prior authorization before I can get my procedure?

It depends. The Department encourages insurers to extend the expiration date of prior authorizations for procedures that were set to take place, but had to be canceled due to a "stay at home" order, if doing so is clinically appropriate. Please talk to your provider and your insurer to determine what arrangements can be made.

6. I'm a provider at a city, county or community clinic that is not in an insurer's network and my claims for COVID-19 diagnostic tests keep getting denied. Is this legal?

No. CARES Act § 3202 requires insurers to cover COVID-19 diagnostic testing regardless of network status.

¹¹ Cal. Ins. Code §§ 10123.13(b) & 10123.147(b).

¹² Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 19230, 19269 (Apr. 6, 2020), available at this link: <https://www.federalregister.gov/d/2020-06990/page-19269>.