OHCA
OHIO HEALTH CARE ASSOCIATION

HOSPICE PROVIDERS & COVID-19 TESTING

QUICK REFERENCE GUIDE

On August 26, 2020, CMS released new survey guidance in QSO 20-38-NH mandating testing of SNF staff which expressly includes contractors such as hospice personnel along with employees. This quick reference guide is a tool to aid hospice providers in navigating the new testing requirements, understanding staff and patient copays, and learn about COVID-19 testing options.

SNF TESTING REQUIREMENTS

On August 26, 2020, CMS released new survey guidance mandating testing of SNF staff which expressly includes contractors such as hospice personnel along with employees.

While previously issued ODH Nursing Home Testing Guidance states that hospice staff should be allowed in SNFs in end-of-life situations without testing, the new guidance from CMS imposes new restrictions.

Now, under the new Federal rules, the SNF must ensure contracted personnel, such as hospice staff, meet the same Federal requirements as employees. The guidance also requires that SNFs obtain documentation that the required testing was obtained in accordance with the Federal requirements. This means that SNFs and hospices must decide who will be responsible for testing hospice staff and, if the hospice is responsible, the SNF will need documentation of test results at the required frequency.

The guidance establishes required testing frequency for SNF staff (including hospice personnel) based on county-level positivity rates. SNFs in counties shown as yellow on the table must test staff at least weekly. In red counties, they must test twice a week. CMS allows green county providers to test only once a month, (although Ohio still requires all SNFs to test employees bi-weekly). In addition, the CMS guidelines contain more testing requirements for SNFs with one or more positive cases (considered an outbreak), including serial re-testing of residents and staff until there are no positive test results. Note that a resident admitted to a SNF with a known diagnosis of COVID-19 does not constitute an outbreak.

EXEMPTIONS

If the SNF does not have a point of care testing machine yet, and the lab is unable to meet a turnaround time of <48 hours on the testing requirement, they may qualify for an exemption from the new CMS routine testing requirements if they can adequately document its efforts to procure compliant testing. This exemption does not apply to the new SNF requirements for testing symptomatic staff and residents or to testing in response to an outbreak. Hospice providers must understand whether the hospice or partner SNFs are responsible for testing hospice staff. If the hospice is responsible, plan to document your efforts to secure test results in the required timeframe so that you can provide that information to partner SNFs upon request. To qualify for the turnaround time exemption, the SNF must provide documentation of the following:

- It does not have a POC unit or cannot obtain enough test strips or other supplies necessary to do the testing.
- Its efforts to contact laboratories to obtain the necessary turn-around time and its lack of success in doing so, including specifying which labs were contacted. The CMS guidance does not establish any minimum number of labs that the center must contact.
- It contacted the local health department.
- It contacted the state health department. While the guidelines do not give the required reason for these local and state health department contacts, the revised survey procedures appended to the QSO indicate that the purpose is to request assistance in obtaining timely testing.

POC TEST MACHINES

By the end of September, all Ohio SNFs are scheduled to receive point of care (POC) test machines for staff and resident testing. The results are nearly immediate. However, there are some concerns regarding limitations on supplies for testing.

SNFs have received additional provider relief funds distributions to cover the cost of testing. SNF providers are also permitted to bill for the POC tests under CLIA waiver requirements. There is no copay for the tests to the beneficiary, and CGS Medicare Part B reimbursement is set at $35.33 per test. Other commercial carriers have set their own rates. The Ohio Department of Medicaid does not have a fee schedule or reimbursement method for this code at this time.

TYPES OF COVID-19 TESTS*

Viral Testing

Authorized assays for viral testing include those that detect COVID-19 nucleic acid or antigen. Viral (nucleic acid or antigen) tests check samples from the respiratory system (such as nasal or oral swabs) or saliva to determine whether COVID-19 is present. Viral tests are recommended to diagnose infection. Some tests are point-of-care tests, often used in emergency rooms, doctor's offices, and outpatient clinics. Other tests must be performed in a laboratory. If there is not a Point-of-Care (POC) device or laboratory at the collection point, samples must be sent (deliver or shipped) to a laboratory for analysis, a process that can take at least 1-2 days

Antibody Testing

The Food and Drug Administration has not authorized antibody testing to diagnose COVID-19, and the CDC does not currently recommend using antibody testing for diagnosis of any infection. In certain situations, antibody tests may be used in conjunction with viral detection tests to support clinical assessment of persons who present late in their illnesses. Antibody tests for COVID-19 can play an important role in surveillance and epidemiologic studies, which can provide insights into the transmission dynamic of the virus among the general population.

**From the CDC Overview of SARS-CoV-2 (COVID-19)*

FINANCIAL OBLIGATIONS AND OTHER CONSIDERATIONS

Orders for Tests

During the PHE, for COVID-19 and related influenza or respiratory syncytial virus clinical diagnostic laboratory tests, Medicare has removed the requirement that the clinical diagnostic laboratory tests must be ordered by a treating physician or non-physician practitioner (NPP) who uses the tests in the management of the patient's specific medical problem.

Patient/Staff Copays and Cost Shares

Per the CMS FAQ on the FFCRA/CARES Act, medically necessary laboratory diagnostic tests for COVID-19 have no copays or deductibles. The requirement also applies for group health plans and group and individual health insurance to cover both diagnostic testing no cost sharing. Covered COVID-19 tests include all FDA-authorized COVID-19 diagnostic tests, COVID-19 diagnostic tests that developers request authorization for on an emergency basis, and COVID-19 diagnostic tests developed in and authorized by states. It also ensures that COVID-19 antibody testing will be covered.

Medicaid Coverage

The Ohio Department of Medicaid allows for pharmacies to bill for and be reimbursed for COVID-19 tests. We are awaiting guidance on coverage of tests billed from other provider types. There are no copays for Medicaid covered COVID-19 tests.

Self Insured Providers

Unless you have a private contract with a laboratory which dictates otherwise, the laboratory should bill your employee's insurance for their COVID-19 tests. If you are a self-insured provider, the cost of the test will be paid by your insurance plan. Otherwise, the costs for tests should be covered by the insurance with no out of pocket expense to your staff.