



COVID 19 Community Testing at Health Centers

Frequently Asked Questions

The following document outlines many of the frequently asked questions related to community health centers hosting community testing for COVID-19 in partnership with the County's Department of Health Services (DHS). The answers reflect the most current information available as of the revision date of this FAQ. CCALAC will continue to expand and refine the document as policies, science and practices develop in response to the coronavirus. Health centers should continue to send their questions to CCALAC to include in future versions of this FAQ. *Standard disclaimer: this is not legal advice.* (Items highlighted in gray are new information).

COUNTY PARTNERSHIP

Q: How can clinics partner with the County on community testing?

Clinics that are interested in partnering with the County on community testing should reach out to Anna Gorman at agorman@dhs.lacounty.gov. The County, in partnership with CCALAC, is providing technical assistance and guidance.

Q: How can clinics get listed on the County testing website?

Reach out to Anna at the email above. DHS will send an excel sheet to complete with details such as how to make an appointment, where the testing is occurring and what hours testing is open.

Q: How do community members make testing appointments at clinics listed on the County website?

Community members make appointments directly with the clinic through a phone number or website provided by the clinic. Clinics do their own registration and appointment scheduling.

Q. Should clinics do drive-through or walk-up testing?

Clinics can conduct either drive-through or walk-up testing.

How do clinics report outcomes?

Providers must report positive test results to DPH with the medical provider reporting form. See directions [here](#).

Q: Do clinics have to do contact tracing?

No. Clinics can do outreach and education to patients and other community members who have tested positive but are not responsible for doing contact tracing. LA County Department of Public Health is responsible for contact tracing.

Q: What kind of swabs should clinics use?

Clinics have the choice of what kind of swabs, but DHS recommends nasopharyngeal (NP) specimens collected by a healthcare provider or nasal mid-turbinate swabs collected by a healthcare provider or by through supervised onsite self-collection.

Q: How many people do clinics have to test each day?

There is no minimum on tests per day but DHS recommends anywhere from 25-100.

Q: Is the county providing testing kits?

No. Clinics work with their existing labs or seek kits through other commercial labs to obtain testing kits. The clinic can bill for the tests or some labs bill plans directly. Information on labs serving LA County can be found [here](#).

Q: What criteria should we follow for testing?

LA County recommends following the County criteria, listed at: <https://covid19.lacounty.gov/testing/>

The criteria are subject to change, but currently includes those with symptoms, close contacts of a COVID-19 infected person while they were infectious (defined as being within 6 feet for more than 15 minutes, or having unprotected contact with exposure to body fluids), those living in congregate settings and asymptomatic people over 65, with a chronic medical condition or essential workers in certain categories.

State Department of Public Health Criteria can be found at:

<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Updated-COVID-19-Testing-Guidance.aspx> (last updated July 14)

Q: What kind of testing is the County recommending?

The County is conducting PCR for diagnostic testing to show if a person is infected, and encourages clinics to do the same. The County is not conducting antibody tests at its testing sites. Antibody testing is not recommended for diagnostic testing currently. Further information on antibody testing can be found [here](#).

Q: How do community testing sites get PPE?

In addition to their usual suppliers, clinics may submit requests for PPE through CICALAC's emergency management program. The County allocates PPE to CICALAC, though it is also dependent on what the County receives. For more information contact Brenda Rodriguez, brodriguez@cicalac.org.

LICENSING

Q: How does a clinic make sure their parking lots/external areas are covered in the state license?

The guidance for temporary waivers of licensing requirements is posted AFL 20-30.1 in <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-30.aspx> (expires on March 1, 2021).

- The waiver includes permission for drive-thru COVID-19 screening/testing and for an intermittent clinic to extend operating hours beyond 40 hours per week.
- Clinics do not need to submit individual program flexibility requests for the regulations specified in the AFL.
- For capacity tracking purposes during COVID-19, PCCs shall submit an application when seeking initial licensure or changing services listed on their license. This shall not require approval before the facility may provide care, although CDPH will reach out to provide technical assistance to ensure patient safety and quality of care.

FEDERAL: FTCA AND SCOPE

Q: Do you have to make the community member a patient of record in order to be covered by FTCA?

In short, yes.

- The [FTCA Health Center Policy Manual](#) explains that patients served by covered individuals at temporary locations included in the covered entity's scope of project are considered the covered entity's patients. As such, the covered entity and its providers are covered by FTCA for services provided during the emergency at temporary locations." Note Section (I) F: **A record of the services provided for each patient should be maintained.**
- Section (I) C.3 of the [FTCA Health Center Policy Manual](#) states in part: "To meet the FTCA requirement of providing services to health center patients, a patient-provider relationship must be established. For the purposes of FSHCAA/FTCA coverage, the patient-provider relationship is established when: ... Health center triage services are provided by telephone or in person, even when the patient is not yet registered with the covered entity but is intended to be registered."
- Click [HERE](#) for recorded FTLF webinar on FTCA Coverage & COVID-19.

Q: Do you have to notify HRSA to add a temporary testing site?

In [PAL 2020-05: Requesting a Change in Scope to Add Temporary Service Sites in Response to Emergency Events](#) HRSA notes that "during an emergency, health centers are likely to participate in an organized state or local response, including by providing primary or preventive care services at temporary locations." Health centers may set up temporary sites that are "within the health center's service area or a county, parish, or other political subdivision adjacent to the health center's service area" (for in-scope services) with notification made to BPHC within 15 days. [PAL 2020-05](#) includes full details and requirements to ensure that the emergency response at temporary locations is considered part of the center's scope of project.

OPERATIONS

Q: Can we get sample workflows for patient and community testing?

Following is one example of a workflow includes a billable provider in the actual testing. Other models will be posted on our website at <https://ccalac.org/resource-library/covid-19-resources/>.

- **Pre Visit:** Prescreen from call center/outreach staff for symptoms and then forward to a physician for test type and next step for care.
 - All callers: verify coverage status through the intake process to confirm they have the coverage they need for testing services (see billing section below for more).
 - Community members: create a patient record to comply with FTCA and other laws.
- **Testing:** Staff with a billable provider and possibly a MA or LVN to assist with documentation and specimen collection. In this scenario the he provider does some assessment of patient and they collect specimen.
 - Intake/registration: Drive up intake completed by MAs that includes an intake/consent form for all patients with demographics, general information, symptoms overview, and permission to test. All patients complete an intake unless recently seen and all is updated in the EHR.
 - Consider a color code system (colored paper on the dashboard of the car to signify level of symptoms) so that the provider knows the status of the patient as they drive up and can prepare the test.
- **Follow up:** All patients (existing or community members) receive their test results within 24-72 hours.
 - Positive Result: Midlevel and MDs provide positive results and counseling, warm handoff to BH if appropriate.
 - Negative Result: For a negative result signed off by a licensed provider, an MA or other non-licensed staff may provide the negative result without interpretation.
 - Contact tracing: Providers document positives to County for record and tracing and the clinic will follow up with the patient to notify them of results, etc. LA County CDPH does the contact tracing for positives. All positives are reported to the County using a [CMR form](#). The county then follows up.

FINANCE/REIMBURSEMENT

Q: How (and who) does a clinic bill for testing:

Per NACHC, Chapter 16 of the Health Center Compliance Manual requires health centers to “make every reasonable effort to collect appropriate reimbursement for its costs” from any “public assistance program” that covers medical expenses - FQHCs who fail to submit claims potentially risk getting a condition on their grant. The following are several scenarios for billing for different types of patients:

- **Patient is enrolled in Medi-Cal and assigned to the testing health center through an IPA.**
 - Health center bills the managed care visit and PPS wrap as normal (assuming testing is performed as part of a billable visit).
 - Lab bills IPA (This is the most common financial arrangement with IPAs. Some health centers have contractual arrangements with their IPAs under which the clinic is financially responsible for lab costs.)

- **Patient is enrolled in Medi-Cal and NOT assigned to the testing health center.**
 - Health center bills PPS wrap as normally would for unassigned patient visit (assuming, as above, that testing is performed as part of a billable visit).
 - Additionally, (as per normal requirements) the provider must attempt to redirect the patient to their in-network managed care provider and document this referral in the patient’s medical record.
- **Patient is Uninsured (includes patients who are enrolled in MHLA)**
 - Patient IS actively enrolled in restricted scope Medi-Cal:
 - No further enrollment should be required.
 - FQHCs bill PPS for COVID-19 testing and related services under the restricted scope aid code so long as the services are provided as part of an otherwise PPS billable visit. Guidance [here](#).
 - Patient IS NOT enrolled in Restricted Scope Medi-Cal - **COVID-19 PE**:
 - Enroll in COVID-19 Presumptive Eligibility (PE) - see [Application Step-by-Step Guide for Providers](#)
 - Under PE aid code V2, FQHCs can bill PPS for testing, testing-related services, and treatment so long as the services are provided as part of a clinic visit with a billable provider that includes typical components of history, assessment, treatment plan, etc.
 - These claims will be reimbursed at PPS.
 - [COVID-19 PE Billing Instruction for FQHCs](#): use ICD-10-CM diagnosis code U07.1 on **all claims** (in Box 66) for reimbursement of COVID-19 medically necessary care for PE individuals in aid code V2. The use of this code in this way, regardless of test result, has been confirmed by DHCS to CPCA in writing. FQHCs should submit claims using the applicable code set, including revenue code, procedure code and modifier (if required) as noted in the Medi-Cal [Clinics and Hospitals provider manual](#).
 - The PE for COVID-19 *enrollment period begins on the date of application* and ends on the last calendar day of the month in which the 60th day falls from the date of the PE application in which the individual was determined eligible for PE. Multiple claims can be submitted during a patient’s PE coverage period (e.g. if patient has need to be tested more than one time).
- **Lab Costs for Uninsured Patients (Not COVID-19 PE, NOT Restricted Scope Medi-Cal):**
 - Labs should not be billing FQHCs for uninsured patients. It is not the FQHCs' role to pay them for services they can be reimbursed for elsewhere. (per NACHC on 6/25)
 - Labs can bill the HRSA Uninsured Claims Program (UCP). While they may choose not to do so, that is their decision. For reference see [this article](#) which references LabCorp and Quest billing the UCP.
 - Quest – Quest can/will submit claims directly to the UCP. Reference this [billing/coding guidance](#). (For Uninsured Patients, select “Uninsured COVID-19 (UNICV)” under the insurance option).
 - LabCorp - Providers may have received a letter from LabCorp providing a choice of whether to have LabCorp submit the claim to the UCP or whether the clinic would do it. Be sure to proactively advise LabCorp to submit to UCP. Ask your LabCorp rep if you are getting bills from LabCorp for uninsured patients.
- **HRSA Uninsured Claims Program:**
 - Federal program operated by HRSA that reimburses providers, “generally at Medicare rates,” for COVID-19 testing and treatment provided to uninsured patients.
 - Payer of last resort program. An eligibility requirement is that “no other payer will reimburse... for COVID-19 testing and/or treatment for that patient.” **There must NOT**

be another payer available for the patient (this includes COVID-19 PE or restricted-scope Medi-Cal). Per HRSA, if Medicaid pays, bill Medicaid first.

- There is not an explicit prohibition on inclusion of undocumented noncitizens in this program, but it is not recommended that this program is used to claim reimbursement for undocumented patients (due to the guidance requiring screening and reporting on patients' eligibility and insurance status and request for SSN. Although SSN is not required -- State ID number is an accepted alternative-- there are some concerns that leaving it blank could place a patient in a vulnerable position. Reportedly many providers (including Quest and LabCorp) are now declining to submit SSNs on claims for this program for security/privacy reasons unrelated to immigration status, potentially reducing concerns related to blank SSN fields).
- **Patient Has Commercial Insurance**
 - **Individuals with commercial insurance should be encouraged to utilize their own providers for testing.** The LA County Health Officer issued an order in July (updated on August 8 and effective September 7), [Access to Diagnostic Testing Through Healthcare Facilities](#), which states that all health care facilities in the county must offer testing to their current or assigned patients who meet specified criteria. The order also requires health care facilities to publicize information through their typical channels about how to access testing. This may help relieve some of the influx of privately insured individuals seeking testing at public testing sites such as those operated by the county and clinics.
 - In California, all DMHC-regulated plans, this covers most "brand name" health plans, are required to cover medically necessary COVID-19 testing. Emergency regulations define COVID-19 testing as medically necessary for enrollees who are "essential workers" regardless of symptoms or exposure.
 - Under DMHC's [APL 20-028 – Emergency Regulation Regarding COVID-19 Diagnostic Testing](#) health plan enrollees are classified into 3 buckets - (1) enrollees with symptoms of or exposure to COVID-19; (2) asymptomatic, unexposed enrollees who are "essential workers"; and; (3) asymptomatic, unexposed enrollees who are not "essential workers" - the COVID testing **access requirements differ for each group.**
 - The federal FFCRA and the CARES Act require health plans to provide COVID-19 testing at **zero cost-sharing for enrollees with symptoms of COVID-19 or known or suspected exposure** to someone with COVID-19. For all other enrollees (without symptoms of or known/suspected exposure), ordinary cost-sharing may be imposed for COVID-19 testing.
 - Health plans may impose prior authorization requirements for enrollees who are not symptomatic, do not have exposure or are not essential workers.
 - Health centers may need to include in their workflow a step to call the plan to confirm. DMHC's FAQ [Health Plan Coverage of COVID-19 Testing](#) provides additional information.
 - Can a health center be reimbursed for testing even if out-of-network? Yes. Under the Families First Act, insurers must reimburse out-of-network providers for COVID-19 tests. If an insured patient comes to a health center for an evaluation *and* the evaluation results in the provider ordering a COVID-19 test, then the cost of the evaluation visit and the test should be 100% covered by insurance. However, if the evaluation *does not* result in the provider ordering a COVID-19 test, then federal law does NOT require the insurer to cover 100% of the cost of the visit.

- How to bill and how much to bill an insurer if out-of-network? The CARES Act **requires** providers that order and/or provide testing to post the cash price of these evaluation and testing services on their public website (no guidance is given re where or how prominently). Clinics should post a fee schedule for testing online somewhere – this is the amount the commercial plan will reimburse. This cash price can be the same or different than the sliding fee scale.
- Under what circumstances can a health center charge sliding fee related to testing? (below is from [HRSA website](#), lightly edited for length)
 - In accordance with current Health Center Program billing and collections requirements, health centers must make every reasonable effort to collect appropriate reimbursement for their costs, including billing Medicare, Medicaid, CHIP, and other public and private insurance or assistance programs, as applicable. Health centers must apply their sliding fee discount schedules consistent with their established policies and procedures.
 - Consistent with health centers’ billing and collections procedures, health centers should ascertain whether there are available reimbursement, funding, or compensation sources and any related cost sharing restrictions for COVID-19 related testing or treatment prior to billing patients. Each health center is responsible for ensuring adherence to any terms and conditions that apply to specific reimbursement, funding, or compensation sources for COVID-19 related testing and treatment.
 - If there are any patient out-of-pocket costs, and no restrictions on cost-sharing, health centers should apply their sliding fee discounts, which are based on income and family size.
 - If there are any applicable prohibitions on patient cost sharing, after submitting their claims for reimbursement to the applicable payor source(s), health centers should not charge patients for such costs.
 - See above for DMHC information regarding cost-sharing for commercially insured patients.
 - [PE for COVID-19](#) covers necessary diagnostic testing, testing-related services and treatment services, including all medically necessary care related to COVID-19, such as the associated office, clinic, or emergency room visits **at no cost to the patient.**
 - The HRSA Claims Reimbursement Program (likely not used by CA/LA health centers due to availability of Medi-Cal reimbursement under COVID-19 PE for uninsured patients) prohibits charging the patient.

CLINICAL

COVID TESTING

Q: What Professions can collect COVID-19 specimens?

HRSA provided the following FAQ link:

<https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions>

States regulate the practice of medicine and other health professions as part of their authority to establish laws and regulations to protect the health, safety, and general welfare of their citizens. Each health center is therefore responsible for maintaining its operations, including developing and implementing its own operating procedures, in compliance with [all Health Center Program requirements](#)

[and all other applicable federal, state, and local laws and regulations](#) (42 CFR 51c.304(d)(3)(v)). This includes requirements regarding laboratory and personnel related to COVID-19 testing.

- Health centers that provide COVID-19 testing must comply with their state’s clinical laboratory laws, including any personnel and training requirements for specimen collection and/or the performance of clinical laboratory testing.
- Health centers must also comply with any applicable CLIA requirements, based on the complexity of the testing. See [CLIA Laboratory Guidance During COVID-19 Public Health Emergency](#) (PDF - 220 KB) and [additional updates from CMS](#).
- Health centers must ensure that any clinical staff conducting specimen collection and testing are appropriately trained, qualified, and, if necessary, supervised, consistent with the health center’s credentialing and privileging procedures. This includes health centers that operate in states, territories, or jurisdictions that do not require licensure or certification for certain clinical staff (e.g., medical assistants) that may be involved in specimen collection.
- If your state authorizes health practitioners (dentists, medical assistants, etc.) to provide services, including COVID-19 specimen collection, outside their usual areas of licensure/certification/practice, this should be documented in the health center’s credentialing files, along with fulfillment of any additional requirements for credentialing and privileging.

For specific questions regarding eligibility and applicability of FTCA coverage, see the [FTCA Health Center Policy Manual](#) (PDF - 407 KB), Section C. Covered Activities, and the March 27, 2020, [Determination of Coverage for COVID-19-Related Activities by Health Center Providers](#) (PDF - 35 KB).

CA Department of Public Health provided additional information on COVID-19 testing:

Collecting specimens using nasopharyngeal or oropharyngeal swabs is not in the scope of practice for personnel licensed under Chapter 3 of the BPC, including phlebotomists, MLTs, and CLS. They are all authorized to collect blood samples but are not authorized to collect samples using swabs.

Lab Field Services defers to other licensing boards on scope of practice issues for their licensees. We have been informed by some other boards of the following scope of practice authorization:

- The Medical Board of California and the Osteopathic Medical Board of California state that allopathic and osteopathic physicians can collect these specimens.
- According to the Dept. of Consumer Affairs medical assistant webpage, medical assistants can collect using nasal swabs, but front of the nose only. They may not collect using nasopharyngeal or oropharyngeal swabs.
- EMTs and paramedics are authorized by the Director of the California Emergency Medical Services Authority to collect nasopharyngeal swabs only for COVID-19 testing and only for the duration of the COVID-19 emergency. Additional information about the local option scope of practice allowing them to do this is available on the California Emergency Medical Services Authority webpage a <https://emsa.ca.gov/covid19/>.
- Registered nurses can collect specimens using nasopharyngeal or oropharyngeal swabs.

- Nasopharyngeal or oropharyngeal swab collection is within the scope of practice for a licensed vocational nurse (LVN) and psychiatric technician (PT) as long as the LVN or PT:
 - Receives specialized instruction in the proper procedure from a registered nurse or licensed physician;
 - Demonstrates the requisite knowledge, skills and ability prior to performance of the procedure; and
 - Performs the procedure in accordance with a licensed physician's order.
- For other licensed personnel, please contact the appropriate licensing board for information about scope of practice.
- Dentists are not automatically qualified to perform COVID-19 testing. For more information from State and County officials, please visit CCALAC COVID-19 resource page at https://ccalac.org/wordpress/wp-content/uploads/Recommendations-from-State-and-County-regarding-Dentist-Performing-COVID-Testing_.pdf.

All the FDA authorized serology tests currently available are classified as either moderate or high complexity. There are a few molecular tests that are classified as waived. For a complete list of authorized tests and the complexity, please consult the FDA EUA page, which is continuously updated as new tests are authorized: <https://www.fda.gov/medical-devices/emergency-use-authorizations-medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices>.

CODING

Q: Are other clinics adding E&M on top of U0001 for COVID testing?

For testing in the office, you can bill an E&M code and bill 87635 for infection agent detection and also bill for the COVID test. The swab testing collected is included in E&M code.

Q: What code do we use for follow-up/result discussion of the previously COVID testing?

Regular E&M code.

Q: What DX do we use for follow-up of a COVID testing with a negative result?

Z11.59 code

Q: Can clinic do COVID testing and flu testing on the same visit? What code do we use for flu point of care testing?

Yes, COVID-19 testing and flu testing can be performed on the same visit. You would bill an E&M code, COVID testing code, and a rapid flu test code. The codes are; 87275 for Influenza B, 87276 for Influenza A, and 87279 for Parainfluenza virus.

Q: How do we bill for Presumptive Eligibility?

Per [COVID-19 PE Billing Instruction for FQHCs](#): FQHCs must use ICD-10-CM diagnosis code U07.1 on **all claims** (in Box 66) for reimbursement of COVID-19 medically necessary care for PE individuals in aid code V2. These claims will be reimbursed at PPS.

QUALITY

Q: How does COVID-19 services changes intersect with PCMH and HRSA quality metrics? What impact/consequences will there be from testing new/non-patients?

CCALAC and others are advocating with BPHC and other payers on issues related to all quality metrics for 2020. In the meantime:

- [HRSA FAQ on UDS Reporting](#)
- [HRSA FAQ on Quality Improvement](#)