Maryland
INSURANCE ADMINISTRATION

COVID-19 PROVIDER FAQs

As of April 16, 2020

1. **What types of plans are covered by emergency rules and laws related to COVID-19?**

   Maryland law applies to individual and group health policies or contracts issued in the state by a nonprofit health service plan such as CareFirst of Maryland, HMOs, or insurance companies regulated by Maryland law.

   Maryland law does not apply to plans that are subject only to federal law, such as self-funded employee benefit plans, Medicare, and the Federal Employee Health Benefits Program (FEHBP). Health plans issued in other states, even if they cover Maryland residents, are subject to the laws of the other state. The federal Centers for Medicare and Medicaid Services (CMS) has released FAQs about the federal requirements that apply to group health plans and health insurers, including self-funded plans. You can review the CMS FAQs at: https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf.

   Additionally, not all plans subject to Maryland law are subject to the emergency regulations activated by the Maryland Insurance Administration. The emergency regulations do not apply to Medicare Supplement plans and have limited applicability to plans that pay a fixed amount for a service. Fixed indemnity plans provide limited benefits that are not based on the actual expenses incurred, so members will be responsible for any charges that exceed the fixed benefit amount. The emergency regulations also do not apply to medical assistance health programs (Medicaid managed care organizations). These entities are subject to regulation by the Maryland Department of Health (MDH).

2. **What types of care are covered by the regulations?**

   Cost-sharing is waived for any visit, regardless of the setting, for diagnosis or testing for COVID-19. Cost-sharing is also waived for laboratory fees for testing. Check with the carrier for which codes to use. Carriers are updating their websites frequently with information.

   Cost-sharing includes deductibles, coinsurance, and copayments.

3. **Do I still need prior authorization for testing or treatment of COVID-19?**

   The federal Families First Coronavirus Response Act, which was signed into law by the President on March 18, 2020, prohibits a carrier from imposing any prior authorization or other medical management requirements on COVID-19 laboratory diagnostic tests and any

items or services provided during office visits, urgent care center visits, or emergency room visits that result in an order for a COVID-19 test. However, carriers may still require prior authorization to consider whether treatment of COVID-19 is medically necessary. Contact the carrier.

If a carrier denies the care relating to COVID-19 on the basis that it is not medically necessary, then it is considered an emergency case. This means that the carrier must expedite the internal grievance process. If the care is still denied after the grievance, the Maryland Insurance Administration will expedite its review if a provider, member, or insured files a complaint.

The Maryland Insurance Administration is authorized to send cases to an independent review organization for an expert opinion on whether the care is medically necessary.

Care denied as experimental is considered a denial based on medical necessity. A carrier is required to expedite an internal review and the Commissioner has the authority to require carriers to provide or reimburse for contractual benefits.

Information about the emergency regulation can be found at: https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2020252.