

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH
Acting Commissioner



Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

HEALTHCARE QUALITY AND SAFETY BRANCH

BLAST FAX 2020-99

TO: Assisted Living Agencies, Residential Care Homes, Home Health Agencies, and Hospice Agencies

FROM: Acting Commissioner Deidre S. Gifford, MD, MPH

CC: Deputy Commissioner Heather Aaron, MPH, LNHA
Adelita Orefice, MPM, JD, CHC, Senior Advisor to the Commissioner
Barbara Cass, RN., Branch Chief, Healthcare Quality and Safety Branch
Donna Ortelle, Section Chief, Facility Licensing and Investigations Section

DATE: October 21, 2020

SUBJECT: BinaxNOW Training Toolkit Webinars

We wanted to share additional information from Abbott on their trainings over the next week. Abbott will be holding webinars through Friday, October 30th to support their BinaxNOW COVID-19 tests. These webinars are designed to reinforce the Training Toolkit and highlight key points that should be kept in mind during BinaxNOW COVID-19 and NAVICA implementation. Please use the following website to register for the trainings:

https://www.whitehatcom.com/alere_binax

Each webinar has space for a limited number of participants, each webinar will have the same content. Please feel free to share this information with organizations within your state or region that may be interested in Abbott's trainings.



Phone: (860) 509-7400 • Fax: (860) 509-7543
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For additional support, please contact the Abbott Rapid Diagnostics Technical Support Services team at 1-800-257-9525 between 8 a.m. – 8 p.m. EST Monday - Friday or by emailing ts.scr@abbott.com.

For additional training videos and documents, please visit the [BinaxNOW™ COVID-19 Ag Card and NAVICA™ App Set-Up and Training portal](#).

External Affairs /HHS BinaxNOW Team

Testing and Diagnostics Work Group

COVID-19 Response Team

For questions regarding the status of your shipment please contact Abbott directly at:

Customer Service: ARDxUSGovernmentSupport@abbott.com or 1-877-441-7440

The website for BinaxNOW distribution is live:

<https://www.hhs.gov/coronavirus/testing/rapid-test-distribution/index.html>

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Interim Guidance for SARS-CoV-2 Antigen Testing and Reporting in Connecticut – September 29, 2020

“Rapid” antigen testing for SARS-CoV-2 can be helpful and lead to more timely contact tracing and testing when timely turnaround times for molecular reverse transcription polymerase chain reaction (RT-PCR) results are not achievable. Antigen tests can provide point-of-care diagnosis for individuals presenting with possible COVID-19 infection and can be more affordable than RT-PCR tests, however detection of viral antigen is generally less sensitive than nucleic acid detection using RT-PCR.

SARS-CoV-2 antigen tests with Emergency Use Authorization (EUA) from the U.S. Food & Drug Administration (FDA) are becoming increasingly available to clinicians for rapid diagnosis of COVID-19.¹ The Centers for Disease Control and Prevention (CDC) and FDA both provide guidance regarding the use of SARS-CoV-2 diagnostic tests, including antigen tests.^{2,3}

This guidance from the Connecticut Department of Public Health (DPH) synthesizes current guidance for the effective use of SARS-CoV-2 antigen tests and outlines reporting requirements. Additional guidance for Abbott BinaxNOW antigen tests is forthcoming.

Summary of Recommendations

- Prioritize PCR for screening asymptomatic individuals.
- Consider using antigen testing for:
 - Symptomatic individuals with recent-onset symptoms consistent with COVID-19
 - Asymptomatic individuals who undergo serial screening (e.g. nursing home staff/residents)
 - Asymptomatic individuals who previously tested positive for SARS-CoV-2 and need asymptomatic screening
- Clinicians should be familiar with the performance characteristics of the antigen tests used and follow manufacturer’s instructions for specimen collection and handling.
- An active CLIA Certificate of Waiver is required before conducting POC antigen testing, and the DPH FDA-EUA Lab [attestation form](#) must be submitted to DPH.FLISLab@ct.gov.
- Patients should be provided the Patient Fact Sheet for the EUA test performed. See Reference #1 for Fact Sheets.
- Report ALL test results (positive and negative) to DPH. Additional case report must be submitted for ALL positive findings, even if confirmatory RT-PCR result is negative. See Reference #9 for detailed instructions.



Phone: (860) 509-7994 • Fax: (860) 509-7910
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
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Considerations for SARS-CoV-2 Antigen Testing

Sensitivity data

Test sensitivity generally wanes as time from symptom onset increases. Sensitivity data for antigen tests with FDA EUAs are generated from comparisons with RT-PCR (percent positive agreement with gold standard). These data are from testing specimens collected from patients who presented with symptoms.

Ordering providers can find sensitivity data in the “Clinical Performance” section on the package insert of any antigen test that received FDA EUA. The manufacturer’s package insert also specifies when confirmation with a molecular assay (i.e. RT-PCR) should be considered for patient management. Clinical performance and the potential need to pursue confirmatory testing should be considered when discussing antigen testing with patients and making decisions regarding the use of antigen testing.

Sensitivity data may change with further validation of these assays. FDA has a SARS-CoV-2 Reference Panel for comparing sensitivities: <https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/sars-cov-2-reference-panel-comparative-data>

Obtaining a Quality Specimen

Most antigen test kits come with nasal or nasopharyngeal swabs, however not all do. Specimen collection instructions provided with each test kit can vary; to achieve optimal consistency and accuracy, follow the manufacturer’s instructions for nasal or nasopharyngeal specimen collection and handling. In some cases, observed self-collection may be possible.

Testing Individuals with COVID-19 Symptoms

Anyone with symptoms suggestive of COVID-19 should self-isolate and seek testing. Isolation should continue while awaiting test results (and as applicable, confirmatory test results). See “Counseling Patients to Self-Isolate at the Time of COVID-19 Testing” below.

Antigen tests are best suited for patients presenting with recent-onset symptoms consistent with COVID-19. Ordering providers should review the “intended use” on the package insert provided by the test manufacturer. The package insert will typically specify:

- The antigen test is intended for patients presenting with symptoms⁴ consistent with COVID-19, and that it is intended for use within a certain number of days after symptom onset.
- In some situations, negative antigen test results in symptomatic patients may be considered “presumptive negative” and confirmation with a molecular assay (i.e. RT-PCR) should be considered for patient management.

CDC and CT DPH recommend confirming negative antigen test results with an RT-PCR test when the pretest probability is high.

- **Pretest probability (the likelihood of COVID-19) is elevated when the patient is symptomatic or has a known exposure to a person confirmed to have COVID-19; confirmatory testing with RT-PCR is recommended for negative antigen test results in these cases.**
- Confirmatory PCR should be obtained as soon as possible within 48 hours of the initial antigen testing.

Testing Individuals Without COVID-19 Symptoms

A highly sensitive test (i.e. RT-PCR) should be considered when screening asymptomatic individuals. If such testing is not feasible, or if turnaround times are prolonged, using antigen tests for screening asymptomatic individuals can be considered even if they are not specifically authorized for this indication (commonly referred to as “off-label” use).³

Antigen testing of asymptomatic individuals can be useful for serial screening in congregate care settings such as nursing homes. CDC provides guidance for the use of antigen tests for serial screening in nursing homes.⁵

Testing Individuals Without COVID-19 Symptoms (cont'd)

When using antigen testing to screen asymptomatic individuals *without the benefit of serial screening*, the need for confirmatory testing (obtain RT-PCR specimen within 48 hours of initial antigen testing) should be considered. **Clinicians should consider the pretest probability (likelihood of COVID-19) when deciding whether order confirmatory testing.**

- **False positives can occur; consider confirmatory testing for positive results when pretest probability is low.**
 - o Low community incidence, no history of exposure, and asymptomatic patient status all lower pretest probability.
 - o Some antigen tests can cross-react with proteins on other Human Coronaviruses, including HKU1, which can cause the common cold.
 - o When asymptomatic screening produces a positive result and pretest probability is low, the patient should isolate until the result of a confirmatory RT-PCR test is available. In congregate settings, the patient should not cohort with known COVID-positive individuals until the diagnosis is confirmed by RT-PCR.
- **False negatives can occur; consider confirmatory testing for negative results when pretest probability is high.**
 - o There is limited data on antigen test sensitivity for asymptomatic individuals.
 - o The lower sensitivity of antigen testing compared to RT-PCR might lead to missed asymptomatic infections.
 - o RT-PCR should be considered when a negative antigen result is obtained for an asymptomatic person who has a known exposure to someone with confirmed COVID-19 (increases pretest probability).² These individuals should quarantine for the full 14-day incubation period regardless of the test result.

Testing Individuals Who Previously Tested Positive for SARS-CoV-2

Individuals who have recovered from COVID-19 can persistently test positive for SARS-CoV-2 by RT-PCR. SARS-CoV-2 RNA shedding can continue in the absence of replication-competent virus in recovered individuals, which is why a test-based strategy (which requires RT-PCR) for lifting of isolation precautions is discouraged.⁶

Retesting is NOT recommended for individuals who previously tested positive for SARS-CoV-2 by RT-PCR (even after a significant exposure to someone with COVID-19) within 3 months/90 days from:

- Symptom onset for the initial COVID-19 infection (if initial infection included symptoms) OR
- The date of the first positive RT-PCR test for SARS-CoV-2 (if initial infection didn't include symptoms)

Asymptomatic recovered individuals with a positive RT-PCR result during this period likely have persistent viral RNA shedding in the absence of replication-competent virus.⁶ Patients who experience a recurrence of symptoms during this period after recovery from COVID-19 can be retested for COVID-19 if there are no alternative etiologies for the illness.⁷

Testing after the 3 month/90-day period:

CDC recommends retesting recovered individuals for SARS-CoV-2 *after* the 3 month/90-day period if they:

- Develop new symptoms consistent with COVID-19 *after* the 3 month/90-day period
- Are identified as close contacts of a COVID-19 case by contact tracing
- Are in a congregate setting undergoing facility-wide testing for outbreak control

When a recovered individual tests positive for COVID-19 by RT-PCR again, decisions regarding whether this represents a new infection and/or infectiousness should be made on a case-by-case basis. Until we know more about reinfection, clinicians should review all available information – medical history, timing of test results, RT-PCR Ct values, and presence of COVID-19 signs and symptoms.⁷ Consider consulting an expert in COVID infections if the data for reinfection is unclear.

Since antigen testing detects viral proteins rather than viral RNA fragments, antigen testing can be considered if testing must be conducted (facility requires pre-procedural screening, for example) for individuals who were previously diagnosed with COVID-19. The utility of SARS-CoV-2 antigen tests for this use has not been evaluated however; more data is needed on the use of antigen tests to screen asymptomatic individuals.

Counseling Patients About Antigen Testing

Given tests with EUA have not undergone the same type of review as an FDA-approved or cleared diagnostic test, **all facilities are mandated by the FDA EUA to provide antigen test fact sheets (available on FDA website, Reference #1) to healthcare providers performing/ordering the test and patients undergoing COVID-19 testing.** Providers should also discuss with patients the reasons for confirmatory testing, as applicable, given the performance characteristics of the antigen test.

Requirements Before Antigen Testing Starts

Healthcare Providers using point-of-care devices under FDA-EUA are required to have an active Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver from CMS.

Facilities with active CLIA Certificate of Waiver:

1. Complete the [DPH FDA-EUA attestation form](#) and return to DPH.FLISLab@ct.gov prior to testing patient samples.
2. Submit a copy of a patient test report OR dummy patient chart OR a narrative as to how the results are being recorded along with the above attestation form.
3. Please also indicate how the test fact sheets for healthcare providers and patients are distributed (via hard copy or electronic link). Fact sheets are available from the manufacturer and on the FDA website (Reference #1)

Facilities with no active CLIA Certificate of Waiver:

1. Complete a [CMS 116 Application form](#) and return to DPH.FLISLab@ct.gov. Once entered into the CMS database, DPH will notify the facility of their CLIA number immediately.
2. Follow steps 1 & 2 above (for facilities with active CLIA Certificate of Waiver).

Federal and State Reporting Requirements

Public Law 116-136, § 18115(a), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, requires “every laboratory that performs or analyzes a test that is intended to detect SARS- CoV-2 or to diagnose a possible case of COVID-19” to report the results from each such test to the Secretary of the Department of Health and Human Services (HHS).⁸ Under HHS guidance, locations offering point-of-care testing are considered “laboratories”, and reporting to HHS is accomplished by transmitting data to state or local public health departments.

DPH has published guidance for reporting **ALL COVID-19 results, both positive and negative, to fulfill both federal and state reporting mandates.**⁹ Test results should be reported to DPH electronically using either HL7 or flat file methods. These options are described in the reporting guidance. Outpatient settings should refer to the section “**COVID-19 Result Reporting by Point of Care Providers or Other Testing Locations**” in the reporting guidance (Reference #9).

In addition to reporting point of care test results, where applicable, healthcare providers must also submit a COVID-19 Case Report Form for each positive test result they receive for a patient.

- If a positive antigen result is followed by a negative PCR result, a case report form still needs to be submitted for the positive antigen result. DPH will receive the negative PCR result through laboratory reporting. These data help public health officials understand the use and impact of antigen testing.
- Providers performing point of care testing can include positive case report information in electronic files as described in the reporting guidance.
- Providers can also submit individual reports for patients with a positive result to a secure online portal at <https://dphsubmissions.ct.gov/Covid/InitiateCovidReport>.

Counseling Patients to Self-Isolate at Time of COVID-19 Testing

Providers who are eligible to bill CMS for counseling services can use existing evaluation and management (E/M) payment codes for CMS reimbursement for counseling about isolation at the time of testing. Please refer to **CMS' counseling checklist**: <https://www.cms.gov/files/document/counseling-checklist.pdf>

- Discuss the need for isolation immediately, even before results are available. This means wearing a mask and limiting interactions with others as appropriate.
- Discuss importance of informing immediate household members that they too should be tested for COVID-19. Review locations and people for possible exposures within the past 2 weeks.
- Review of COVID-19 signs and symptoms.
- Encourage them to provide information to a contact tracer if they test positive and are called.
- Discuss services available to them to aid in isolating at home.

Counseling Patients After a Significant Exposure to COVID-19

Anyone, whether symptomatic or not, who has had a significant exposure to someone with COVID-19 should self-quarantine at home for 14 days (maximum incubation period) after their last exposure. A significant community exposure is generally considered as close contact < 6 feet for \geq 15 minutes, *regardless of mask use*.¹⁰ Risk assessment for healthcare personnel considers PPE use.¹¹

Quarantined individuals should stay home, at least 6 feet away from others, and avoid contact with people at higher risk for severe illness as they self-monitor for symptoms.

- If symptoms develop during the 14-day quarantine, the individual should follow home isolation guidance for COVID-19 infection and seek medical care and testing.
- A person who tests negative during their 14-day quarantine period should continue to self-quarantine until the end of their 14-day quarantine period.
- If an individual does not develop symptoms during the 14-day quarantine period, then they may be released from self-quarantine.

References

¹FDA. Individual EUAs for Antigen Diagnostic Tests for SARS-CoV-2: <https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/vitro-diagnostics-euas#individual-antigen>

²CDC. Interim Guidance for Rapid Antigen Testing for SARS-CoV-2: <https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html>

³FDA. FAQs on Testing for SARS-CoV-2: <https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/faqs-testing-sars-cov-2>

⁴CDC. Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19):

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html#clinical-presentation>

⁵CDC. Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html>

⁶CDC. Decision Memo: Duration of Isolation and Precautions for Adults with COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>

⁷CDC. Clinical Questions about COVID-19: Patients with Persistent or Recurrent Tests: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Patients-with-Persistent-or-Recurrent-Positive-Tests>

⁸HHS. COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115: <https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf>

⁹CT DPH. Reporting SARS-CoV-2 (COVID-19) Test Results and Cases: Guidance for Laboratories, Point of Care Providers, and Others: https://portal.ct.gov/-/media/DPH/HAI/COVID19-Test-Reporting_092020V11.pdf

¹⁰CDC. Public Health Guidance for Community-Related Exposure: <https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html>

¹¹ CDC. Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

Additional Guidance from The Association of Public Health Laboratories (APHL): Considerations for Implementation of SARS-CoV-2 Rapid Antigen Testing: <https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/APHL-SARSCov2-Antigen-Testing-Considerations.pdf>

Decision Framework: RT-PCR versus Antigen Testing for SARS-CoV-2

Patient Presentation	RT-PCR (Gold Standard, No confirmation necessary)	Antigen (May need confirmation: performs best during early acute infection)
Symptomatic (diagnosis)	Gold standard for diagnosis of COVID-19	<p>Highly sensitive if used within period of “intended use” per manufacturer’s recommendation.</p> <p>Negative results may be “presumptive” and need confirmation, particularly if specimen obtained outside of period of “intended use” per manufacturer’s recommendation.</p> <p>Positive results do not need confirmation.</p>
		<p>Off-label (outside the authorization) use if no clinical suspicion of COVID-19 infection or exposure.</p> <p>Limited data, test performance for asymptomatic cases is unknown.</p>
Asymptomatic (screening)	Preferred test for asymptomatic individuals	<p>Confirmatory RT-PCR test recommended if:</p> <ul style="list-style-type: none"> • Presumptive negative result and high pretest probability (i.e. known exposure to someone with COVID-19). • Presumptive positive result and low pretest probability (i.e. no exposure or facility outbreak, low community incidence) <p>Can be used for serial testing of asymptomatic residents and staff of congregate settings (such as long-term care) without confirming presumptive negatives.</p> <ul style="list-style-type: none"> • Confirmatory testing for presumptive positives recommended if no known outbreak/exposure in facility and low community incidence. • Isolate (do not cohort residents with presumptive positive results together with residents positive by RT-PCR) until results are available from confirmatory results.

Decision Framework: COVID-19 Testing for Individuals with Prior RT-PCR confirmed diagnosis of COVID-19

Patient Presentation	RT-PCR (Gold Standard, No confirmation necessary)	Antigen (May need confirmation: performs best during early acute infection)
Prior RT-PCR confirmed diagnosis of COVID-19	<p>Consider using if reinfection suspected and no other etiologies for illness have been identified.</p> <p>Positive result may reflect persistent RNA shedding OR new infection.*</p> <p>Negative results rule out COVID-19.</p>	<p>Consider using if reinfection is suspected, or if the patient needs to be screened for COVID-19 for any reason.†</p>

*When making decisions about infectiousness following a positive result, clinicians should review all available information – medical history, timing of test results, RT-PCR Ct values, and presence of COVID-19 signs and symptoms.

†Utility of SARS-CoV-2 antigen tests for these purposes has not been evaluated

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Addendum: Interim Guidance for Abbott BinaxNOW™ COVID-19 Antigen Card Recipients in Connecticut – October 14, 2020

This document provides interim guidance for the use of the Abbott BinaxNOW™ SARS-CoV-2 antigen test from the State of Connecticut, which has Emergency Use Authorization (EUA) from the U.S. Food & Drug Administration (FDA). This document is an addendum to [Interim Guidance for SARS-CoV-2 Antigen Testing and Reporting in Connecticut](#) released by the Connecticut Department of Public Health (DPH) on September 29, 2020.

“Rapid” antigen testing for SARS-CoV-2 can be helpful and lead to more timely contact tracing and testing when timely turnaround times for molecular reverse transcription polymerase chain reaction (RT-PCR) results are not achievable. Antigen tests can provide point-of-care (POC) diagnosis for individuals presenting with possible COVID-19 infection. Detection of viral antigen is generally less sensitive than nucleic acid detection using RT-PCR however, which could lead to erroneous results.

Summary of Guidance

- Recipients should review and understand DPH’s [Interim Guidance for SARS-CoV-2 Antigen Testing and Reporting in Connecticut](#).
 - Ordering providers should be familiar with the performance characteristics of the BinaxNOW™ and follow manufacturer’s instructions for specimen collection and handling.
 - DPH recommends adhering to the manufacturer’s “intended use” (patients with symptoms suggestive of COVID-19 within the first 7 days of symptom onset) as described in the [Instructions for Use](#).
 - Until more data are available, all negative BinaxNOW™ results in patients with high suspicion (pretest probability) for COVID-19 should be confirmed by a RT-PCR test for SARS-CoV-2.
 - DPH recommends confirming positive antigen results with RT-PCR when suspicion for COVID-19 is low due to the potential for false positives.
 - Positive antigen results do not necessarily need confirmation by RT-PCR when suspicion for COVID-19 is high.
- Personnel involved in the collection and handling of specimens must complete [Abbott’s training modules](#).
- [Appropriate PPE](#) must be used for specimen collection and handling, and PPE must be provided by the testing institution.
- An active CLIA Certificate of Waiver is required before conducting POC antigen testing, and DPH’s [attestation form](#) must be submitted to DPH.FLISLab@ct.gov.
- Any institution receiving BinaxNOW™ tests from the State of Connecticut must report ALL test results (positive and negative) to DPH in an *electronic* format [as specified by DPH](#). Additional case reporting is required for all positive SARS-CoV-2 findings.



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- Patients must be counseled on the interpretation and implications of their result, whether positive or negative.
- Patients must be provided the [Patient Fact Sheet](#) for the BinaxNOW™, as this is a test that has received EUA from the FDA.
- Patients must be provided results in written form (hard copy or secure electronic format). For options, explore Abbott's Navica™ smartphone application or CDC's ["Ready, Set, Test" booklet](#).

Considerations for SARS-CoV-2 Testing with the Abbott BinaxNOW™

Test sensitivity generally wanes as time from symptom onset increases. Sensitivity data for antigen tests with FDA EUAs are generated from comparisons with RT-PCR (percent positive agreement with gold standard). These data are from testing specimens collected from patients who presented with symptoms suggestive of COVID-19.¹

Ordering providers should carefully review the "Limitations" section of the [Instructions for Use](#). They can also find sensitivity data in the "Clinical Performance" section.

- Clinical performance and the potential need to pursue confirmatory testing should be considered when discussing antigen testing with patients and making decisions regarding the use of antigen testing.
- For the BinaxNOW™, there is no published performance data for patients under the age of 22 years (as of October 10, 2020).
- Data for testing of asymptomatic individuals is limited.

Sensitivity data may change with further validation studies. FDA has a [SARS-CoV-2 Reference Panel](#) for comparing sensitivities.

Personnel involved in collection should be trained to follow the [instructions for use](#). Specimen quality can vary with specimen collection technique, particularly with self-collection. FDA does not specifically authorize self-collection for the BinaxNOW™. If self-collection is done, due to potential for inadequate sampling, FDA [recommends providing clear instructions](#) to patients who self-collect their specimens under observation.²

Testing Individuals Without COVID-19 Symptoms

A highly sensitive test (i.e., RT-PCR) should be considered when screening asymptomatic individuals. If such testing is not feasible, or if turnaround times are prolonged, using antigen tests for screening asymptomatic individuals can be considered even if they are not specifically authorized for this indication (commonly referred to as "off-label" use).³

If a clinician or facility would like to screen asymptomatic individuals for SARS-CoV-2 using antigen tests, DPH recommends consulting an expert in laboratory medicine or infectious diseases. The DPH Infectious Diseases Section can also offer guidance, however DPH does not currently have recommendations for asymptomatic screening using antigen tests for SARS-CoV-2 beyond the nursing home setting, for which the Centers for Disease Control and Prevention (CDC) has guidance for serial screening.⁴

DPH recommends confirming positive antigen results with RT-PCR when pretest probability is low (e.g., asymptomatic person, no ongoing outbreak in a facility, low community incidence) due to the potential for false positives. In this situation, the individual with the positive antigen result should be isolated away from others while awaiting confirmatory testing results. In congregate settings, this person should not be cohorted with individuals who could be infectious with COVID-19 until RT-PCR confirmatory results are available.

Counseling Patients About Antigen Testing

Given tests with EUA have not undergone the same type of review as an FDA-approved or cleared diagnostic test, **all facilities are mandated by the FDA EUA to provide antigen test fact sheets to healthcare providers performing/ ordering the test and patients undergoing COVID-19 testing.** These fact sheets can be found on the [FDA website](#). Providers should also discuss with patients the reasons for confirmatory testing with RT-PCR, as applicable, given the performance characteristics of the antigen test.

Requirements Before Antigen Testing Starts

Healthcare Providers using point-of-care devices under FDA-EUA are required to have an active Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver from CMS.

Facilities with active CLIA Certificate of Waiver:

1. Complete the [DPH's FDA-EUA attestation form](#) and return to DPH.FLISLab@ct.gov prior to testing patient samples.
2. Submit a sample of a patient test report OR dummy patient chart OR a narrative as to how the results are being recorded along with the above attestation form.
3. Please also indicate how the test fact sheets for healthcare providers and patients are distributed (via hard copy or electronic link). Fact sheets are available from the manufacturer and on the [FDA website](#).

Facilities with no active CLIA Certificate of Waiver:

1. Complete a [CMS 116 Application form](#) and return to DPH.FLISLab@ct.gov. DPH will notify the facility of their CLIA number immediately after entering into the CMS database.
2. Follow steps 1 & 2 above (for facilities with active CLIA Certificate of Waiver).

Federal and State Reporting Requirements

Public Law 116-136, § 18115(a), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, requires “every laboratory that performs or analyzes a test that is intended to detect SARS- CoV-2 or to diagnose a possible case of COVID-19” to report the results from each such test to the Secretary of the Department of Health and Human Services (HHS).⁵ Under HHS guidance, locations offering point-of-care testing are considered “laboratories”, and reporting to HHS is accomplished by transmitting data to state or local public health departments.

DPH has published [guidance](#) for reporting **ALL COVID-19 results, both positive and negative, to fulfill both federal and state reporting mandates.** Test results should be reported to DPH electronically using either HL7 or flat file methods. These options are described in the reporting guidance. Outpatient settings should refer to the section “COVID-19 Result Reporting by Point of Care Providers or Other Testing Locations” in the reporting guidance.⁶

In addition to reporting point of care test results, healthcare providers must also submit a COVID-19 Case Report Form for each positive test result they receive for a patient.

- **If a positive antigen result is followed by a negative PCR result, a case report form still needs to be submitted for the positive antigen result.** DPH will receive the negative PCR result through laboratory reporting. These data help public health officials understand the use and impact of antigen testing.
- Providers performing point of care testing can include positive case report information in electronic files as described in the reporting guidance.
- Providers can also submit individual reports for patients with a positive result to a secure online portal at <https://dphsubmissions.ct.gov/Covid/InitiateCovidReport>.

Counseling Symptomatic Patients to Self-Isolate at Time of COVID-19 Testing

Symptomatic patients should be counseled to self-isolate.

- Discuss the need for isolation immediately, even before results are available (if RT-PCR result pending). This means wearing a mask and limiting interactions with others as appropriate.
- Discuss importance of informing immediate household members that they too should be tested for COVID-19. Review locations and people for possible exposures within the past 2 weeks.
- Review of COVID-19 signs and symptoms.
- Encourage them to provide information to a contact tracer if they test positive and are called.
- Discuss [services available](#) to them to aid in isolating at home.

Providers who are eligible to bill CMS for counseling services can use existing evaluation and management (E/M) payment codes for CMS reimbursement for counseling about isolation at the time of testing. Please refer to **CMS' counseling checklist:** <https://www.cms.gov/files/document/counseling-checklist.pdf>

Counseling Patients After a Significant Exposure to COVID-19

Anyone, whether symptomatic or not, who has had a significant exposure to someone with COVID-19 should self-quarantine at home for 14 days (maximum incubation period) after their last exposure. A significant community exposure is generally considered as close contact < 6 feet for ≥ 15 minutes, *regardless of mask use*.⁷ Risk assessment for healthcare personnel considers PPE use.⁸

Quarantined individuals should stay home, at least 6 feet away from others, and avoid contact with people at higher risk for severe illness as they self-monitor for symptoms.

- If symptoms develop during the 14-day quarantine, the individual should follow home isolation guidance for COVID-19 infection and seek medical care and testing.
- A person who tests negative during their 14-day quarantine period should continue to self-quarantine until the end of their 14-day quarantine period.
- If an individual does not develop symptoms during the 14-day quarantine period, then they may be released from self-quarantine at the end of the 14-day period without the need for clearance testing.

References

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⁵HHS. COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115: <https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf>

⁶CT DPH. Reporting SARS-CoV-2 (COVID-19) Test Results and Cases: Guidance for Laboratories, Point of Care Providers, and Others: https://portal.ct.gov/-/media/DPH/HAI/COVID19-Test-Reporting_092020V11.pdf

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⁸CDC. Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

Additional Guidance

CDC: Interim Guidance for Rapid Antigen Testing for SARS-CoV-2: <https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html>

FDA: Individual EUAs for Antigen Diagnostic Tests for SARS-CoV-2: <https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/vitro-diagnostics-euas#individual-antigen>

Association of Public Health Laboratories (APHL): Considerations for Implementation of SARS-CoV-2 Rapid Antigen Testing: <https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/APHL-SARSCov2-Antigen-Testing-Considerations.pdf>

CDC: Ready, Set, Test Booklet for Waived Tests: <https://www.cdc.gov/clia/docs/waived-tests/ready-set-test-booklet.pdf>

