CDH/MGB

SARS-COV-2 TESTING POLICY – 6.15.20

This policy provides criteria for nucleic acid amplification testing (NAAT) for SARS-CoV-2 (aka COVID-19 PCR testing). Serological testing is discussed separately. Current testing capacity is adequate to permit providers to test at their discretion but this will be continually revisited in accordance with testing demand and test capacity. NAAT testing will be prioritized based on the criteria below. See Infection Statuses and Resolution for details on resolution of infection statuses linked to testing and results.

A. Testing Criteria

1. **Symptomatic patients.** All patients (ambulatory, inpatient) with symptoms consistent with COVID-19 should be tested. These patients will be identified as CoV-Risk when the order for testing is placed and require Enhanced Respiratory Isolation (ERI) pending their evaluation. Symptoms consistent with COVID-19 infection include:
    - Subjective/documented fever,
    - New sore throat,
    - New cough,
    - New runny nose/nasal congestion,
    - New shortness of breath,
    - New muscle aches, or
    - New loss of smell or taste,
    - Atypical symptoms concerning for COVID-19 (e.g., COVID toes)
2. **Asymptomatic patients.** Testing is a priority in the following clinical situations.
    a. Admission, planned or unplanned
        i. Patients with planned admission should be tested prior to or on admission. If tested prior to admission, testing within 48 hours of admission is preferred but tests obtained in the 72 hours prior to admission will suffice as admission test. Please see Partners Infection Control Guidance for Aerosol-Generating Procedures (AGP) for guidance if an AGP is anticipated or planned.
        ii. Patients admitted to the hospital who have not been tested in the prior 72 hours will be tested upon admission. Please see Partners Infection Control Guidance for Aerosol-Generating Procedures for guidance if an AGP is anticipated or planned.
        iii. Admission testing for **asymptomatic** CoV-Recovered patients is strongly discouraged (see below). These patients should be cared for under Standard Precautions.
    b. Aerosol-Generating Procedures (AGPs)
        i. Outpatients with planned or anticipated AGPs should be tested in the 72 hours prior to the AGP. Please see Partners Infection Control Guidance for Aerosol-Generating Procedures for guidance on use of ERI pending a test and Standard Precautions when negative result returns.

ii. Emergency Department and inpatients tested under 2a above do not require additional testing prior to inpatient AGPs.
iii. Special circumstances. The optimal frequency of repeat testing in outpatients with serial, frequent AGPs planned (e.g., three times weekly electroconvulsive therapy that requires mask ventilation) has not been established. Providers can elect one of the following options:
    1. Test in the 72 hours prior to each AGP to allow the AGP to proceed under Standard Precautions with a negative pre-AGP test, OR
    2. Test less frequently and follow ERI for the AGPs occurring outside the 72 hour testing window, OR
    3. Do not test and follow ERI for all AGPs
iv. Please note that pre-AGP testing for asymptomatic CoV-Recovered patients is strongly discouraged (see below). These patients should be cared for under Standard Precautions.

c. Other Circumstances for Testing in Asymptomatic Patients.
    1. As needed for patient placement (e.g., SNF, hemodialysis, home health, to or from congregate setting, Department of Child and Family Services, etc.)
    2. Solid organ transplant, BMT, CAR-T, and leukemia induction/consolidation or other high-intensity chemotherapy
    3. Organ donation
    4. Neonates born to mother with confirmed COVID-19 at 24 hours of life. Repeat testing at 48 hours per discretion of local Infection Control and Infectious Diseases
    5. Retest indeterminant/inconclusive COVID19 result, Infection Control Special Investigations (ordered by Infection control or designee), or to resolve infection status per Partners Policy
    6. Subjects on Partners-approved research protocol
    7. Positive serology for COVID-19 (IgM or IgG) within prior 10-days. Consider if patient has a forthcoming in-person visit within 10 days of test.
    8. Individuals in close contact, within the last 14 days with a confirmed COVID-19 case.
    9. Per Occupational Health Services
    10. Per provider discretion

B. **Testing After Recovery from COVID-19.** Viral RNA can persist for weeks following infection, however, patients in whom viral RNA is detected by NAAT after resolution of their illness and resolution of COVID-19 are not considered infectious and do not require ERI.
    a. Do not test asymptomatic patients who have recovered from COVID-19 and have had their COVID-19 infection status resolved per Partners Infection Status Resolution Criteria for 6 weeks from the resolution of COVID-19 infection status. These patients will be identified in EPIC as “CoV-Recovered.” CoV-Recovered will auto-resolve at the end of 6 weeks.

i. Testing Asymptomatic CoV-Recovered patients is strongly discouraged. These patients should be cared for following Standard Precautions.
ii. If tested during this period and positive by NAAT, decisions regarding patient infection status, isolation, and any other actions are per local infection control.

b. Testing is recommended for patients with recurrent symptoms. CoV-Risk will be assigned at the time of testing, and these patients will require ERI until CoV-Risk status is resolved.

C. **Other Considerations**

a. Patients who refuse testing.
   i. Patients who refuse testing when indicated under 1, 2a, and 2b will be considered as at risk for COVID-19. Providers should order CoV-Risk for these patients and managed following ERI.
b. Testing performed outside of Partners locations.
   a. Performing the test at a Partners location is preferred.
   b. If not performed at a Partners location, the ordering provider must ensure the result is entered as described.