

Regence

Electronic pre-authorization via Availity Essentials

Steps to submitting an authorization request

Updating Express Entry

Use Availity's Express Entry to ensure your contact information is up to date.

1. Sign in to Availity Essentials, [availity.com](https://www.availity.com)
2. From the main menu, select My Providers>Express Entry
3. Select which section you would like to edit (physical address, phone, etc.)

Note: When an administrator adds a National Provider Identifier (NPI) to their organization's Express Entry, the data comes from the NPPES NPI Registry. This information can be edited if it is not current/accurate.

Electronic authorization application

Use Availity's electronic authorization application to determine whether pre-authorization is required for a medical service and to submit your medical pre-authorization requests.

The authorization application will let you know, before submitting the request, whether the service:

- Is excluded from coverage
- Doesn't need pre-authorization
- Needs pre-authorization by Regence
- Needs pre-authorization through a vendor partner (e.g., AIM Specialty Health [AIM] or eviCore healthcare [eviCore])
- Needs pre-authorization through our joint administration third-party administrators (e.g., AmeriBen or Innovative Care Management for Zenith)

Note: Our current pre-authorization requirements, guidelines and timeframes apply to electronic authorizations.

Accessing the authorization application

1. Sign in to Availity Essentials, [availity.com](https://www.availity.com)
2. From the main menu, select Patient Registration>Authorizations & Referrals
3. From the Authorizations & Referrals menu, select Authorizations
4. Select Payer from the drop-down list
5. Select Organization from the drop-down list
 - ~Some users have access to multiple organizations

The screen will refresh and change once the payer and organization are selected.

Ask your organization administrator for help if you don't find the authorization application in your menu options. Click **My Administrators** to locate your organization's administrator contact information.

Step 1 – Start an authorization

Select the authorization type that applies to your request (i.e., inpatient or outpatient).

The screenshot shows the Availity web application interface for starting an authorization. The top navigation bar includes the Availity logo, Home, Notifications (5), My Favorites, Utah, Help & Training, Demo's Account, and Logout. Below this is a secondary navigation bar with Patient Registration, Claims & Payments, My Providers, Reporting, Payer Spaces, and More, along with a Keyword Search field. The main content area is titled 'Authorizations' and features a progress indicator with four steps: 1. Start an Authorization (highlighted), 2. Add Service Information, 3. Rendering Provider/Facility, and 4. Review and Submit. The 'Start an Authorization' form includes fields for Organization (ABC Clinic), Payer (REGENCE BCBS OF UTAH), and Request Type (Inpatient Authorization). A dropdown menu for 'Authorization Type' is open, showing options for 'Inpatient Authorization' (highlighted in blue) and 'Outpatient Authorization'. A 'Next' button is located at the bottom left of the form.

Step 1 – Start an authorization

All fields are required, unless specified as optional.

Select to show optional fields if additional information would be helpful in the submission.

Member information

1. Enter member ID – including prefix
2. Enter patient first name
3. Enter patient last name
4. Enter patient date of birth

Requesting provider

1. Search by NPI or name
2. Select Role Code - provider or facility
3. Enter NPI or name
4. Click **Retrieve Provider Info**
5. Select result (if more than one result)

The screenshot shows the Availity web application interface for starting an authorization. The top navigation bar includes the Availity logo, Home, Notifications (2), My Favorites, Utah, Help & Training, Leslie's Account, and Logout. Below the navigation bar are links for Patient Registration, Claims & Payments, My Providers, Reporting, Payer Spaces, and More. A search bar is located on the right side of the navigation bar.

The main content area is titled "Authorizations" and includes a "Give Feedback" button, a "Go to Dashboard" button, and a "New Request" button. Below this is a progress indicator with five steps: 1. Start an Authorization (highlighted), 2. Add Service Information, 3. Rendering Provider/Facility, 4. Add Attachments, and 5. Review and Submit.

The "Start an Authorization" section contains a summary table with the following information:

Transaction Type	Organization	Payer
Outpatient Authorization	Cambia	REGENCE BCBS OF UTAH

Below the summary table is the "MEMBER INFORMATION" section, which includes a "SHOW OPTIONAL FIELDS" checkbox. The fields are:

- Member ID (text input)
- Relationship To Subscriber (dropdown menu, currently set to "Self")
- Patient First Name (text input)
- Patient Last Name (text input)
- Patient Date of Birth (calendar icon and text input)

Below the member information is the "REQUESTING PROVIDER" section, which includes a "SHOW OPTIONAL FIELDS" checkbox. The fields are:

- Search By (dropdown menu, currently set to "NPI")
- Role Code (dropdown menu, currently set to "Provider")
- NPI (text input)
- Retrieve Provider Info (button)

At the bottom of the form are "Back" and "Next" buttons. The version number "v2.828.3" is displayed at the bottom right of the page.

No matches found

If the requesting provider search does not return a match, check the Role Code value for the NPI entered. It may need to be changed between provider and facility.

If the provider is not on file, the information can be entered manually. Both the NPI and tax ID are required for the requesting provider.

REQUESTING PROVIDER

Search By

NPI

Role Code

Facility

NPI

1669484473

Retrieve Provider Info

Contact information

Contact phone number and email address should automatically populate from the requesting provider information.

Optional: Add an extension for the direct contact phone number, in the Contact Extension field.

Required: Confidential voicemail is required by our clinical intake team in the event they need to contact you.

If prepopulated contact information is incorrect, corrections can be made in Express Entry.

REQUESTING PROVIDER SHOW OPTIONAL FIELDS

Can't find who you are searching for? [Search Again](#) [Enter Manually](#)

Express Entry optional

Select Provider ...

Provider Role

Provider

First Name

Last Name

NPI

Tax ID

Specialty / Taxonomy

Address Line 1

City

State

ZIP Code

Contact Name

Contact Phone

Contact Extension optional

Confidential Voicemail

Contact Fax

Contact Email Address

Confidential Voicemail

Yes - This contact number has a confidential voicemail

No - This contact number is not a confidential voicemail

Step 1 – Start an authorization

After entering member and requesting provider information, the member eligibility and benefit check will run to verify whether the member's coverage is active. Query will check the provider's contract status and member's coverage.

Checking member eligibility.



Verifying provider contract status.



Verifying member plan.



Step 2 – Add service information

- Select service type
- Select place of service
 - For outpatient requests, enter from/to date
 - For inpatient requests, enter
 - Admission date
 - Admission type
 - Level of care

Optional field - Service quantity/type:

- Outpatient authorizations - specify the number of visits, units, or time frames for the service or therapy being requested.
- Inpatient authorizations - specify the number of hospital admission days being requested.
- Select level of service
- Enter diagnosis code(s)
- Enter procedure code(s) (up to 10 codes)
 - Key in code, or
 - Type in description and select code, or
 - Select code from drop-down list

Click the + icon to add additional procedure codes. (Click the X icon to remove a procedure code.)

Note: For inpatient pre-authorization requests, the procedure code(s) is optional.

Home > Authorizations & Referrals > Authorizations

Authorizations Give Feedback Go to Dashboard New Request

1 Start an Authorization 2 **Add Service Information** 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

SERVICE INFORMATION SHOW OPTIONAL FIELDS

Service Type

Place of Service

From Date To Date

Level Of Service

Expedited Review

Definition: When the member's physician/provider believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

I certify that this request meets the following definition for expedited review

DIAGNOSIS CODE(S) SHOW OPTIONAL FIELDS

Diagnosis Code

+ Add another diagnosis code

PROCEDURE CODE(S) SHOW OPTIONAL FIELDS

Procedure Code Type

+ Add another procedure code

Back Next

v2.921.21

Step 3 – Rendering provider/facility

Service provider

- For inpatient requests, service provider is optional.
- For outpatient requests, facility is optional.
- If the requesting and servicing provider are the same, click the **Use Requesting Provider Information** box
- If the requesting provider is **not** the same as the servicing provider:
 - Search by NPI or name and location
 - Select role code
 - Click **Retrieve Provider Info**
 - Select result (if more than one result)

Click the + icon to add a service provider/facility. (Click the X icon to remove a service provider/facility.)

The screenshot shows the Avallity web application interface. The top navigation bar includes the Avallity logo, Home, Notifications (4), My Favorites, Utah, Help & Training, Leslie's Account, and Logout. Below the navigation bar are tabs for Patient Registration, Claims & Payments, My Providers, Reporting, Payer Spaces, and More. A search bar is located on the right. The main content area is titled 'Authorizations' and includes a breadcrumb trail: Home > Authorizations & Referrals > Authorizations. There are buttons for 'Give Feedback', 'Go to Dashboard', and 'New Request'. A progress indicator shows five steps: 1. Start an Authorization, 2. Add Service Information, 3. Rendering Provider/Facility (highlighted), 4. Add Attachments, and 5. Review and Submit. The 'SERVICE PROVIDER' section has a checkbox for 'Use Requesting Provider Information' and a 'SHOW OPTIONAL FIELDS' checkbox. Below this is a 'Search By' dropdown menu set to 'NPI', a 'Role Code' dropdown menu set to 'Service Provider', and an 'NPI' input field. A blue 'Retrieve Provider Info' button is positioned below these fields. To the right of the 'Role Code' and 'NPI' fields, there are two bullet points: '• For Provider – select Service Provider' and '• For Facility, DME, Lab – select Service Location'. At the bottom of the form, there are links for 'Add another Service Provider' and 'Add a Facility (optional)', and 'Back' and 'Next' buttons.

Procedure code validation

The request will be validated between steps 3 and 4.

The message shown below indicates that the procedure code entered requires additional steps to receive authorization for the service.

- Messaging may indicate a phone or fax number to complete the request.
- A **Next Steps** button may appear which will route the request to MCG to complete additional steps.
 - Click **Take me to MCG Health** to create a secure connection.

Note: If an authorization is required, and the above does not apply, the request will continue to a screen where attachments can be added.

The screenshot displays a web interface with a main content area and a modal dialog box. The main content area is titled "Authorization Required with Clinical Documentation" and contains a table with the following information:

Service Type	Place of Service	Service From - To Date
5 - Diagnostic Lab	81 - Independent Laboratory	2020-10-19 - 2020-10-21

Below the table, the "Expedited" status is listed as "NA".

The "Diagnosis Code 1" is "Z803 - Family history of malignant neoplasm of breast".

The "Procedure Code 1" is "81162 - BRCA1 & 2 GEN FULL SEQ DUP/DEL" with a "Quantity" of "NA".

The "Status" is "AUTH REQUIRED" (indicated by a red box), and the "Message" field is empty.

The modal dialog box is titled "Next Steps: MCG Health Clinical Questionnaire" and contains the following text:

This request requires you to answer additional clinical questions with the insurance company's utilization management partner, **MCG Health**.

Secure connection to:



Click "Take me to MCG Health" to create a secure connection in a new browser tab.

At the bottom of the dialog, there are two buttons: "Not Now" and "Take me to MCG Health" (with a lock icon).

Below the main content area, there is a "Next Steps" button.

Step 4 completed - overview

After completing the MCG Health clinical questionnaire, the next step is to add attachments.

Home > Authorizations & Referrals > Authorizations

A Authorizations Give Feedback Go to Dashboard New Request

4 Clinical Documentation **5 Add Attachments** **6 Review and Submit**

Member ID [REDACTED]	Date of Birth [REDACTED]	Gender Female
Relationship to Subscriber Spouse	Subscriber Name [REDACTED]	
Eligibility Status Active Coverage	Group Number [REDACTED]	Plan / Coverage Date [REDACTED]
Transaction Type Outpatient Authorization	Organization The Regence Group ID - USE THIS ACCOUNT ONLY FOR TESTING	Payer REGENCE BCBS OF OREGON

MCG Health Clinical Questionnaire completed!

Thanks for completing the additional clinical documentation questionnaire.
Please click "Next" to continue the authorization process.

Next

Step 4/5 – Add attachments

If your request was routed to MCG Health, Step 4 add attachments will be shown as Step 5.

1. Click **Add files**.
2. Navigate to the supporting clinical documentation file on your computer.
3. Click **Open** to upload the file to this request.
4. To add more files, click **Add files**.

The screenshot shows the Availity portal interface. At the top, there are navigation links for Home, Notifications (5), My Favorites, Utah, Help & Training, Demo's Account, and Logout. Below this is a search bar and a menu with options like Patient Registration, Claims & Payments, My Providers, Reporting, Payer Spaces, and More. The main content area shows a progress bar with five steps: 1. Start an Authorization, 2. Add Service Information, 3. Rendering Provider/Facility, 4. Add Attachments (highlighted), and 5. Review and Submit. Below the progress bar is a patient information card for Jane Doe, including Member ID, Date of Birth, Gender, Relationship to Subscriber, Subscriber Name, Eligibility Status, Group Number, Plan / Coverage Date, Transaction Type, Organization, and Payer. Below the card is an 'ADD ATTACHMENT(S)' section with an 'Add files' button. A blue banner below the button contains the warning: 'Attachments may be up to 60MB in size, but the total of all attachments cannot exceed 150MB.' At the bottom of the form are 'Back' and 'Next' buttons.

Note: Fax numbers are not displayed on the portal because they differ by line of business and service type. For more information, visit our provider website, regence.com, for more information.

Examples of types of files to attach include:

- History & physical
- Treatment history
- Laboratory/radiology/testing results
- Chart notes
- Current symptoms & functional impairments

File types that are accepted:

- TIF
- JPG
- PDF
- Doc or Docx

File size limits:

- Individual files must be 60MB or less*
- The total of all files must be 150MB or less

*If file is too large or user is unable to attach the file, create a Word document stating that user will fax the needed file, attach this to the request.

Example: Supporting clinical documentation file >60MB, Will fax documentation for certification/reference number: xxxxxxxx.

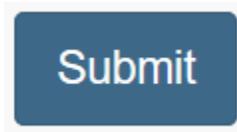
Fax documentation to us with certification/reference #.

Step 5/6 – Review and submit

Prior to submitting the request, review all details and information entered.

If edits are needed to any of the information, use the **Back** button to return to that step.

Click the **Submit** button to submit the request and see the results.



Sending authorization request to payer.



1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

DOE, JANE Patient
Member ID: ABC123456789 Date of Birth: 08/03/1960 Gender: NA
Relationship to Subscriber: Spouse Subscriber Name: DOE, JOHN
Eligibility Status: Active Coverage Group Number: 112 Plan / Coverage Date: 12/27/2015 - 12/31/9999
Transaction Type: Inpatient Authorization Organization: ABC Clinic Payer: REGENCE BCBS OF UTAH

Member Information [Back to Step 1](#)

Patient Name: DOE, JANE Patient Date of Birth: 08/03/1960
Member ID: ABC123456789 Relationship to Subscriber: Spouse Subscriber Name: DOE, JOHN

Requesting Provider [Back to Step 1](#)

Name: PROVIDER, GREGORY NPI: 3234567899 Tax Id: 123456789
Specialty: 2084N0402X Provider Role: Primary Care Provider
Address: 123 Main St, Any City, WA 92354
Phone: (555) 555-5555 Fax: (904) 444-4444 Contact Name: Demo Nelson

Service Information [Back to Step 2](#)

Service Type: 1 - Medical Care Place of Service: 21 - Inpatient Hospital Admission - Discharge Date: 10/09/2018
Admission Type: Elective
Expedited: NA Level Of Care: Other
Diagnosis Code 1: Z3A12 - 12 weeks gestation of pregnancy Qualifier Code: ABK

Rendering Provider/Facility [Back to Step 3](#)

Provider Name: ABC Hospital NPI: 3234567899 Tax Id: 987654321
Specialty: 2084N0402X Provider Role: Facility
Address: 123 Main St, Any City, WA 92354

Attachment(s) [Back to Step 4](#)

Attachment 1
File Name: Demo_Test_Document.pdf Document Id: 107056/53c4753c-f6c4-4fad-b331-458d86a9225f

[Back](#) [Submit](#)

Authorization response

The response will show details such as the certification or reference number and the status.

Certificate information

- Your reference number is the certification/reference number
- Status – Pended
- Review reason–Disposition pending review
- Payer message–this is your submission receipt

Tip: Print this page or note the certification/reference number for your records.

Transaction ID: 15311252	Customer ID: 16464	Transaction Date: 2021-03-02
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Member ID [REDACTED]	Date of Birth [REDACTED]	Gender Female
Relationship to Subscriber Spouse	Subscriber Name [REDACTED]	
Eligibility Status Active Coverage	Group Number [REDACTED]	Plan / Coverage Date [REDACTED]
Transaction Type Outpatient Authorization	Organization The Regence Group ID - USE THIS ACCOUNT ONLY FOR TESTING	Payer REGENCE BCBS OF OREGON

[Print](#)

Certificate Information

Reference Number [REDACTED]	Status PENDED
---------------------------------------	-------------------------

Review Reason 1
Disposition pending review

Message
Your request has been received. Check status via the Dashboard. Standard turn-around times for authorization reviews apply. Contact the Health Plan with questions.

Member Information

Other authorization responses

Status and review reasons

No action required - Duplicate request

The information user entered is a duplicate to a request already received, and the certification/reference number of the original request is provided:

Certificate Information		
Certification/Reference Number NA	Previous Review Authorization Number 002476104	Status No Action Required
Review Reason 1 Duplicate Request		
Effective Date	Expiration Date	

Contact Payer - Certification responsibility of external review organization

This message displays when a request is submitted for one of our joint administration groups. Request the pre-authorization per the instructions on our provider website.

Certificate Information	
Certification/Reference Number NA	Status Contact Payer
Review Reason 1 Certification Responsibility of External Review Organization	
Effective Date	Expiration Date
Payer Message Prior authorization for these services must be obtained through AmeriBen. For questions call 1 800 786 7930.	

Certificate Information	
Certification/Reference Number NA	Status Contact Payer
Review Reason 1 Certification Responsibility of External Review Organization	
Effective Date	Expiration Date
Payer Message Prior authorization for these services must be obtained through Innovative Care Management. For questions call 1 800 862 3338.	

Auth/Referral dashboard

Use the Auth/Referral dashboard to check the status of submitted pre-authorization requests, cancel or update a request.

Facilities and service providers can check the status of any pre-authorization requests submitted on Availity Essentials for which they are identified.

- Service providers can include primary care providers (PCPs), treating providers or admitting, attending and operating providers, in addition to facilities and independent laboratories.

The dashboard shows:

- All requests submitted, in-process or completed
- The status (e.g., approved, denied, pending review, no action required) of each submitted request, including the individual status for requested services and/or inpatient levels of care.
- **Note: Updating or canceling a request is only available if the request is in a pended status**

Accessing the Auth/Referral dashboard

In the Availity Essentials menu:

1. Patient registration
2. Authorizations & Referrals
3. Auth/Referral Dashboard

The image displays two screenshots of the Availity Essentials dashboard. The top screenshot shows the main menu with 'Patient Registration' highlighted, and a red circle '1' next to it. The middle screenshot shows the 'Authorizations & Referrals' page with a red circle '2' next to the 'Auth/Referral Dashboard' link. The bottom screenshot shows the 'Auth/Referral Dashboard' page with a red circle '3' next to it.

The top screenshot shows the Availity Essentials menu with the following items: Patient Registration (highlighted), Claims & Payments, My Providers, Reporting, Payer Spaces, and More. A red circle '1' is next to Patient Registration. The middle screenshot shows the 'Authorizations & Referrals' page with the following items: Multi-Payer Authorizations & Referrals, Auth/Referral Inquiry, Referrals, Authorizations, and Auth/Referral Dashboard (highlighted). A red circle '2' is next to Auth/Referral Dashboard. The bottom screenshot shows the 'Auth/Referral Dashboard' page with the following items: AIM Specialty Health, Online Batch Management, Clinical Auth Management, Current Admissions Report (Humana), Radiology Referral Submission (Humana), Referral Notifications (Humana), Referral Report (Humana), Drug Prior Authorization (CCStpa), Prior Authorization - Medical Drug Online Request Form (CCStpa), and Authorization Management (Humana). A red circle '3' is next to the Auth/Referral Dashboard link.

Auth/Referral dashboard overview

Home > Auth/Referral Dashboard Need help? Watch a demo about the Auth

Auth/Referral Dashboard Give Feedback New Request ▾

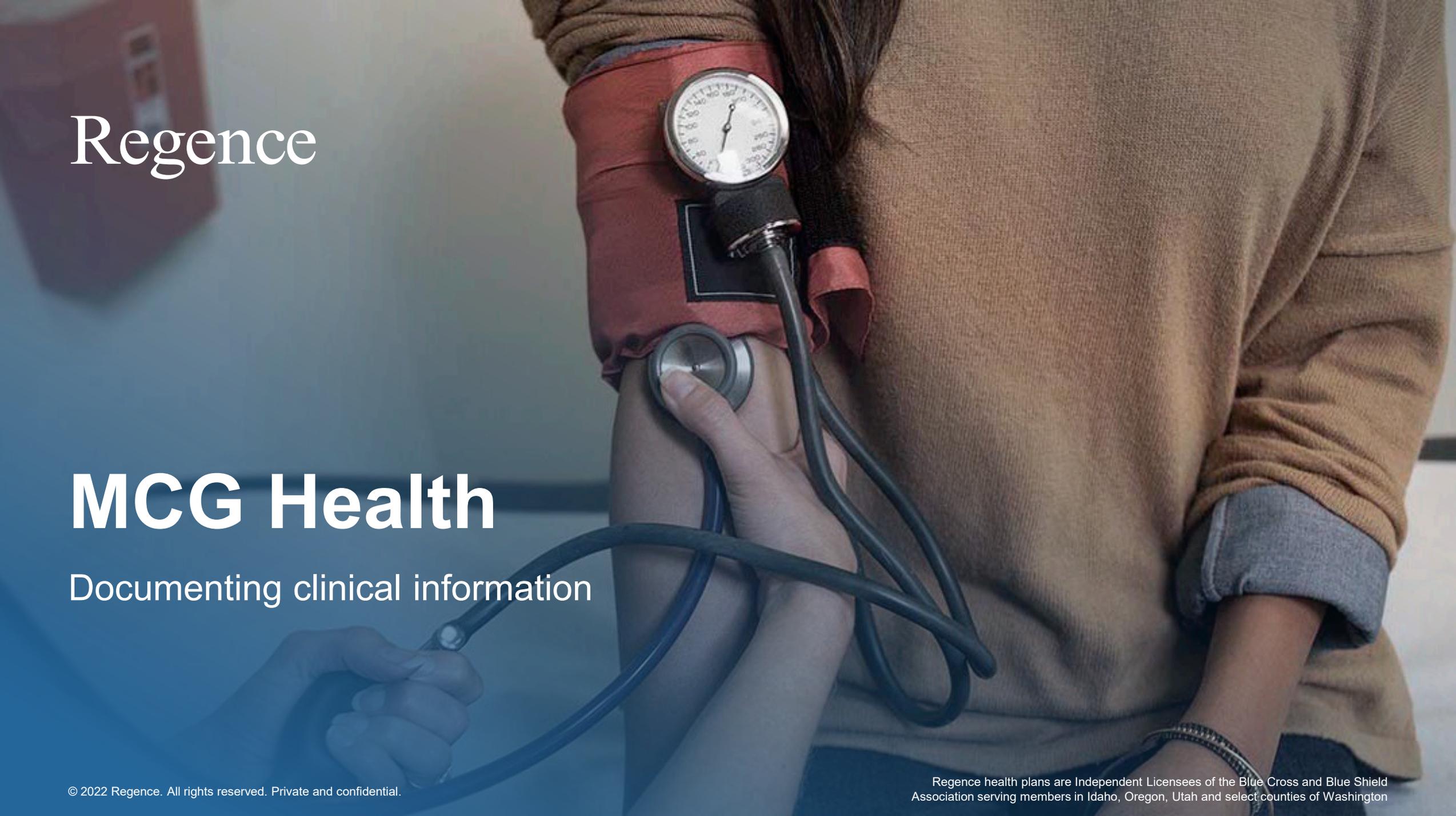
Applied Filters: STATUS: ALL TYPE: ALL ORGANIZATION: ALL DATE RANGE: LAST 4

Sort by: Last Updated List View Detail View

Type	Cert #	Patient	Payer	Submitted	Last Updated	Service Info	Status	View/Action
Authorization Inpatient	[Redacted]	[Redacted]	REGENCE BLUESHIELD	2021-10-23	3 weeks ago	2021-11-21 - 2021-11-23	APPROVED	[Icons]

Callout Boxes:

- Top Right:** You can start a new request from the Dashboard.
- Top Left:** Type indicates the type of request; Referral* or Authorization (inpatient or outpatient)
- Top Center:** Last Updated lists the date the request was last updated.
- Top Right:** Status shows real-time status of submission.
- Bottom Left:** The Cert # is the Certification/Reference number assigned.
- Bottom Center-Left:** The Patient field displays the patient's name, member ID, and date of birth.
- Bottom Center:** Submitted lists the date the request was submitted.
- Bottom Center-Right:** Service Info lists the date or date range submitted on the request.
- Bottom Right:** View/Action is the icon you click to view details, print, and follow or unfollow an item.
- Bottom Left (Detail View):** Detail View

A close-up photograph of a person's arm wearing a red blood pressure cuff. A healthcare professional's hand is visible, holding a stethoscope against the person's arm. The background is a blurred clinical setting.

Regence

MCG Health

Documenting clinical information

MCG Cite AutoAuth

- Regence partners with MCG Health using automated, evidence-based system, Cite AutoAuth.
- Cite AutoAuth presents health plan's specific criteria for provider documentation.
- Reduces the overall time it takes to review a pre-authorization request.

Getting to MCG Health

Click **Take me to MCG Health**

Next Steps: MCG Health Clinical Questionnaire ✕

This request requires you to answer additional clinical questions with the insurance company's utilization management partner, **MCG Health**.

Click "Take me to MCG Health" to create a secure connection in a new browser tab.

Secure connection to:
MCG Health

Determining Clinical Questionnaire Status.



Determining SSO values.



Steps to document clinical indications

1. Review disclaimers
2. Document clinical indications for codes
3. Submit request

1 Disclaimers

81405 - CPT/HCPCS

- To preview full versions of our medical policies please visit: <http://blue.regence.com/trgmedpol/contents/index.html>
- Member is on a **Commercial plan**. If multiple policies display below, be sure to **select a Commercial policy**.
- For genetic testing requests, please select a specific applicable policy. If there is not a specific policy, select Reproductive Carrier Screening for Genetic Diseases (GT81) for reproductive carrier screening or Genetic and Molecular Diagnostic Testing (GT20) for all other requests, which will be reviewed.
- Select the medical policy and accompanying criteria based on the date of service/blood draw date.
- ****By submitting this request, I attest that I have selected the accurate policy criteria for the requested service(s) and I have submitted clinical documentation that accurately supports the selected criteria.****

Procedure Code: 81405 (CPT/HCPCS)

Requested Units: 1

Description : Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis) ABCD1 (ATP-binding cassette, sub-family D [ALD], member 1) (eg, adrenoleukodystrophy), full gene sequence ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), full gene sequence ACTA2 (actin, alpha 2, smooth muscle, aorta) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence ACTC1 (actin, alpha, cardiac muscle 1) (eg, familial hypertrophic cardiomyopathy), full gene sequence ANKRD1 (ankyrin repeat domain 1) (eg, dilated cardiomyopathy), full gene sequence APTX (aprataxin) (eg, ataxia with oculomotor apraxia 1), full gene sequence ARSA (arylsulfatase A) (eg, arylsulfatase A deficiency), full gene sequence BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, t

2 Document Clinical

3

Submit Request

Cancel Request

Back

Review disclaimers

Disclaimers provide the correct medical policy by plan for that member or provide additional instructions.

Disclaimers

81405 - CPT/HCPCS

- To preview full versions of our medical policies please visit: <http://blue.regence.com/trgmedpol/contents/index.html>
- Member is on a **Commercial plan**. If multiple policies display below, be sure to **select a Commercial policy**.
- For genetic testing requests, please select a specific applicable policy. If there is not a specific policy, select Reproductive Carrier Screening for Genetic Diseases (GT81) for reproductive carrier screening or Genetic and Molecular Diagnostic Testing (GT20) for all other requests, which will be reviewed.
- Select the medical policy and accompanying criteria based on the date of service/blood draw date.
- ****By submitting this request, I attest that I have selected the accurate policy criteria for the requested service(s) and I have submitted clinical documentation that accurately supports the selected criteria.****

Document clinical indications for codes

- Review the clinical indications for each procedure code by clicking **Document Clinical**.
- Select **all** relevant indications.

Procedure Code: 81405 (CPT/HCPCS)

 Document Clinical

Procedure Code: 81406 (CPT/HCPCS)

 Document Clinical

Policy guidelines

- All applicable guidelines will display
- Select guideline based on:
 1. Title matching procedure
 2. Line of business as stated in disclaimer, e.g., Commercial, FEP, HTCC*
 3. Effective date of guideline
- Select policy by clicking **add**

Disclaimers

81163 - CPT/HCPCS

- Select the medical policy and accompanying criteria based on the **date of service/blood draw date.**
- **Member is on an FEP plan.** If multiple policies display below, be sure to **select an FEP policy.**
- ****By submitting this request, I attest that I have selected the accurate policy criteria for the requested service(s) and I have submitted clinical documentation that accurately supports the selected criteria.****

Procedure Code: 81163 (CPT/HCPCS)

Requested Units: 1

Description : BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis

Guideline Title	Product Code	Action
Commercial Evaluating the Utility of Genetic Panels April 1, 2022	AC Commercial GT64_Effective_04_01_2022	add
Commercial Genetic Testing for Hereditary Breast and Ovarian Cancer and Li-Fraumeni Syndrome May 1, 2021	AC Commercial GT02_v2_Effective_05_01_2021	add
FEP Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast or Ovarian Cancer Syndrome and Other High-Risk Cancers April 1, 2021	AC FEP 2.04.02_Effective_04_01_2021	add
FEP Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast or Ovarian Cancer Syndrome and Other High-Risk Cancers January 1, 2022	AC FEP 2.04.02_Effective_01_01_2022	add
No Guideline Applies		add

Document clinical indications for codes

- Review any notes for further guidance or instructions
- Select the indications that apply
- Do not select indications that do not apply
- If incorrect guideline is selected, click **Cancel** to go back to the list of policies
- Review the list of information needed for review
- Click **Save**

MEDICAL POLICY CRITERIA

Note: This policy does not address testing for genetic syndromes that have a wider range of symptomatology, of which seizures may be one, such as the neurocutaneous disorders (e.g., Rett syndrome, neurofibromatosis, tuberous sclerosis) or genetic syndromes associated with cerebral malformations or abnormal cortical development, or metabolic or mitochondrial disorders

The procedure is/was needed for appropriate care of the patient because of ...

- I. Single gene and targeted panel testing for genetic epilepsy syndromes (see Policy Guidelines, Table PG1) may be considered **medically necessary** for individuals suspected of having a genetic epilepsy syndrome when all of the following are met (A. - D.): ...
- II. Single gene and targeted panel testing for genetic epilepsy syndromes to determine reproductive carrier status in prospective parents may be considered medically necessary when one or more of the following are met for the epilepsy syndrome being tested: ...

The healthcare resource is/was not covered because of

- III. Epilepsy syndrome genetic testing for reproductive carrier status is considered **not medically necessary** when Criterion II. is not met. [🔗](#)
- IV. Genetic testing to diagnose genetic epilepsy syndromes is considered **not medically necessary** for patients who do not have severe seizures affecting daily functioning and/or interictal EEG abnormalities, and for patients that have not had EEG and neuroimaging (CT or MRI), or when another clinical syndrome has been identified that would explain a patient's symptoms. [🔗](#)
- V. Genetic testing to diagnose genetic epilepsy syndromes is considered **investigational** for patients with seizure onset in adulthood (age 18 and older). [🔗](#)

^ LIST OF INFORMATION NEEDED FOR REVIEW

SUBMISSION OF DOCUMENTATION

In order to determine the clinical utility of gene test(s), all of the following information must be submitted for review. If any of these items are not submitted, it could impact our review and decision outcome:

- Name of the genetic test(s) or panel test
- Name of the performing laboratory and/or genetic testing organization (more than one may be listed)
- The exact gene(s) and/or mutation(s) being tested
- Relevant billing codes
- Brief description of how the genetic test results will guide clinical decisions that would not otherwise be made in the absence testing
- Medical records related to this genetic test:
 - o History and physical/chart notes, including specific signs and symptoms observed, related to a specific epileptic syndrome
 - o Known family history related to a specific epileptic syndrome, if applicable
 - o Conventional testing and outcomes
 - o Conservative treatments, if any

[✔ Save](#) [✕ Cancel](#)

Criteria

- Criteria will indicate if **one or more** and/or **all of the following** must be met
- The three dots (...) mean there are criteria below
- Click the box next to the criteria to open

MEDICAL POLICY CRITERIA

Note: This policy does not address testing for genetic syndromes that have a wider range of symptomatology, of which seizures may be one, such as the neurocutaneous disorders (e.g., Rett syndrome, neurofibromatosis, tuberous sclerosis) or genetic syndromes associated with cerebral malformations or abnormal cortical development, or metabolic or mitochondrial disorders

The procedure is/was needed for appropriate care of the patient because of ...

- I. Single gene and targeted panel testing for genetic epilepsy syndromes (see Policy Guidelines, Table PG1) may be considered **medically necessary** for individuals suspected of having a genetic epilepsy syndrome **when all of the following are met (A. - D.):** ...
- II. Single gene and targeted panel testing for genetic epilepsy syndromes to determine reproductive carrier status in prospective parents may be considered medically necessary when one or more of the following are met for the epilepsy syndrome being tested: ...

The healthcare resource is/was not covered because of

- III. Epilepsy syndrome genetic testing for reproductive carrier status is considered **not medically necessary** when Criterion II. is not met. [🔗](#)
- IV. Genetic testing to diagnose genetic epilepsy syndromes is considered **not medically necessary** for patients who do not have severe seizures affecting daily functioning and/or interictal EEG abnormalities, and for patients that have not had EEG and neuroimaging (CT or MRI), or when another clinical syndrome has been identified that would explain a patient's symptoms. [🔗](#)
- V. Genetic testing to diagnose genetic epilepsy syndromes is considered **investigational** for patients with seizure onset in adulthood (age 18 and older). [🔗](#)

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 - o Known family history related to a specific epileptic syndrome, if applicable
 - o Conventional testing and outcomes
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✓ Save

✗ Cancel

Investigational or not medically necessary services

- Scroll to the bottom to review the investigational or not medically necessary criteria.
- If one of these indications applies, you must select it.

MEDICAL POLICY CRITERIA

Note: This policy does not address testing for genetic syndromes that have a wider range of symptomatology, of which seizures may be one, such as the neurocutaneous disorders (e.g., Rett syndrome, neurofibromatosis, tuberous sclerosis) or genetic syndromes associated with cerebral malformations or abnormal cortical development, or metabolic or mitochondrial disorders

The procedure is/was needed for appropriate care of the patient because of ...

- I. Single gene and targeted panel testing for genetic epilepsy syndromes (see Policy Guidelines, Table PG1) may be considered **medically necessary** for individuals suspected of having a genetic epilepsy syndrome when all of the following are met (A. - D.): ...
- II. Single gene and targeted panel testing for genetic epilepsy syndromes to determine reproductive carrier status in prospective parents may be considered medically necessary when one or more of the following are met for the epilepsy syndrome being tested: ...

The healthcare resource is/was not covered because of

- III. Epilepsy syndrome genetic testing for reproductive carrier status is considered **not medically necessary** when Criterion II. is not met. [🔗](#)
- IV. Genetic testing to diagnose genetic epilepsy syndromes is considered **not medically necessary** for patients who do not have severe seizures affecting daily functioning and/or interictal EEG abnormalities, and for patients that have not had EEG and neuroimaging (CT or MRI), or when another clinical syndrome has been identified that would explain a patient's symptoms. [🔗](#)
- V. Genetic testing to diagnose genetic epilepsy syndromes is considered **investigational** for patients with seizure onset in adulthood (age 18 and older). [🔗](#)

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[✓ Save](#) [✗ Cancel](#)

List of information needed for review

- Review the list of information needed for review prior to clicking **Save**
- This will assist you in medical record selection for uploading and submission

The procedure is/was needed for appropriate care of the patient because of ...

- I. Single gene and targeted panel testing for genetic epilepsy syndromes (see Policy Guidelines, Table PG1) may be considered **medically necessary** for individuals suspected of having a genetic epilepsy syndrome when all of the following are met (A. - D.): ...
- II. Single gene and targeted panel testing for genetic epilepsy syndromes to determine reproductive carrier status in prospective parents may be considered medically necessary when one or more of the following are met for the epilepsy syndrome being tested: ...
 - A. There is at least one first- or second-degree relative diagnosed; or [↗](#)
 - B. Reproductive partner is known to be a carrier. [↗](#)

The healthcare resource is/was not covered because of

- III. Epilepsy syndrome genetic testing for reproductive carrier status is considered **not medically necessary** when Criterion II. is not met. [↗](#)
- IV. Genetic testing to diagnose genetic epilepsy syndromes is considered **not medically necessary** for patients who do not have severe seizures affecting daily functioning and/or interictal EEG abnormalities, and for patients that have not had EEG and neuroimaging (CT or MRI), or when another clinical syndrome has been identified that would explain a patient's symptoms. [↗](#)
- V. Genetic testing to diagnose genetic epilepsy syndromes is considered **investigational** for patients with seizure onset in adulthood (age 18 and older). [↗](#)

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[✓ Save](#)

[✗ Cancel](#)

[✓ Submit Request](#)

[✗ Cancel Request](#)

[← Back](#)

Single guideline

If only one guideline is available for a code after clicking **Document Clinical**, the criteria will open immediately.

Procedure Code: 43659 (CPT/HCPCS)
Requested Units: 1

Commercial SUR111 - Commercial Gastric Electrical Stimulation May 1, 2018 - (AC)
This content has neither been reviewed nor approved by MCG Health.

The procedure is/was needed for appropriate care of the patient because of ...

- I. Gastric electrical stimulation may be considered medically necessary in the treatment of chronic intractable nausea and vomiting secondary to gastroparesis of diabetic, idiopathic or post-surgical etiology when all of the following (A-C) criteria are met: ...
- By checking all of the boxes below, I acknowledge that the service(s) requested does not fall into any of the categories below (each box must be checked). ...

[✓ Save](#) [✕ Cancel](#)

If the guideline does not apply, click **Cancel** to go back and select **add** for No Guideline Applies.

Procedure Code: 43659 (CPT/HCPCS)
Requested Units: 1

Guideline Title	Product	Code	Action
Commercial Gastric Electrical Stimulation May 1, 2018	AC	Commercial SUR111	add
No Guideline Applies			add

No guideline applies

- If none of the guidelines apply, click **add** for No Guideline Applies.
- Enter notes in the text box (1,000-character limit).

No Guideline Applies

Test for No Guideline Applies
If more than 1,000 characters are needed for documentation, attach the information on the Availity Portal.

864 characters left for notes.

Submit request

- After all codes have been documented, click **Submit Request**.
- The **Submit Request** button is unavailable until all codes have been documented.
- You will be routed back to Availity Essentials and cannot return to MCG Health without starting over.

✓ **Procedure Code:** 43659 (CPT/HCPCS) [▼ show more](#)

Requested Units: 1

✓ **Procedure Code:** 43647 (CPT/HCPCS) [▼ show more](#)

Requested Units: 1

✓ **Submit Request** [← Back](#)

Questions and who to contact

- Visit our provider website, **regence.com**, for:
 - Information on electronic authorizations (For Providers>Provider Tools>Pre-authorization>Electronic Authorizations – [Learn more](#))
 - Provider Contact Center phone numbers (Home>Contact Us)
 - Pre-authorization lists and information
- Call the phone number for providers on the back of the member's ID card
- Questions about pre-authorizations? Follow your normal process
- If your request is still in pended status, you can update it from the dashboard to:
 - Add additional clinical documents
 - Edit service information and/or edit providers
- Email your feedback to us: DL-RegencePre-authorizationFeedback@regence.com
- Use the feedback button on Availity Essentials