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**
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**
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

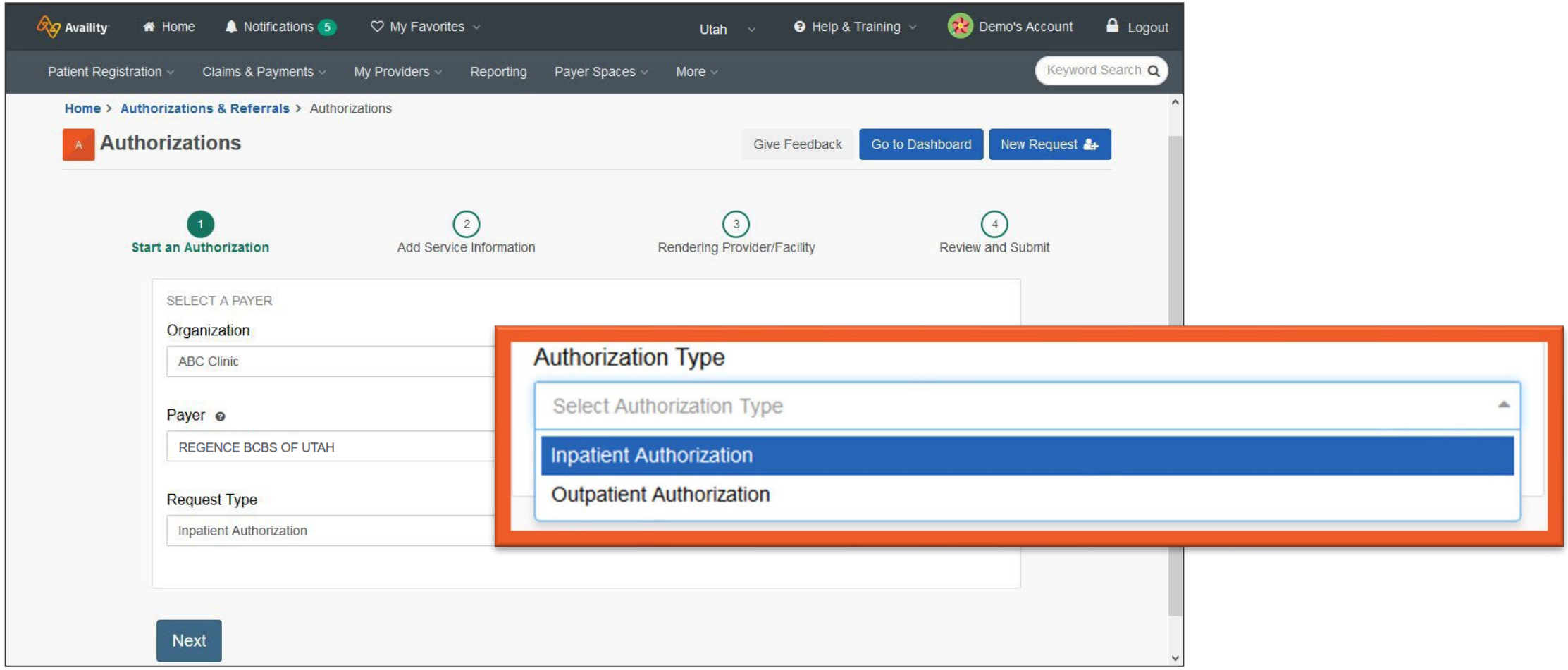
   ~Some users have access to multiple organizations

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).



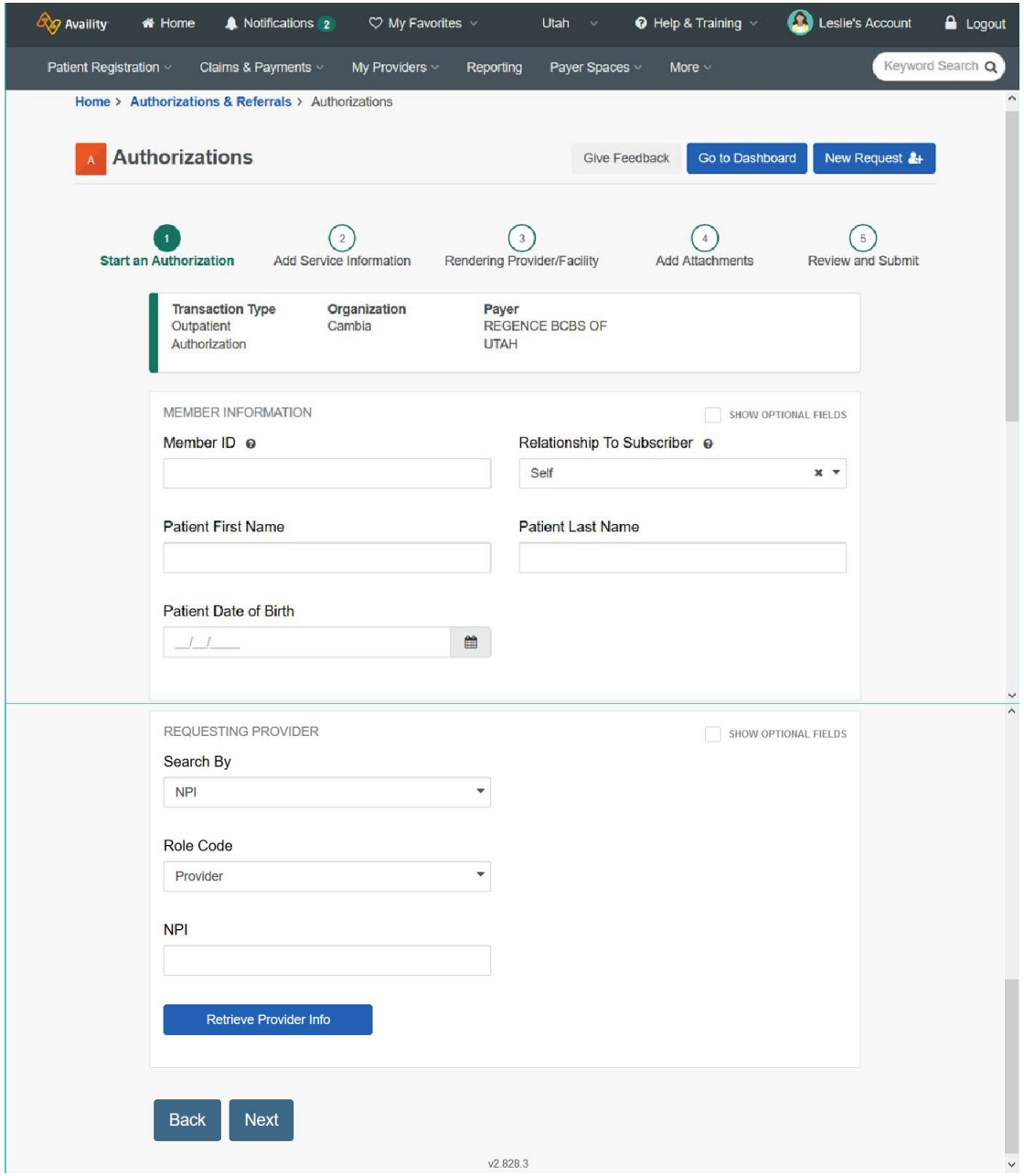
Step 1 – Start an authorization

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

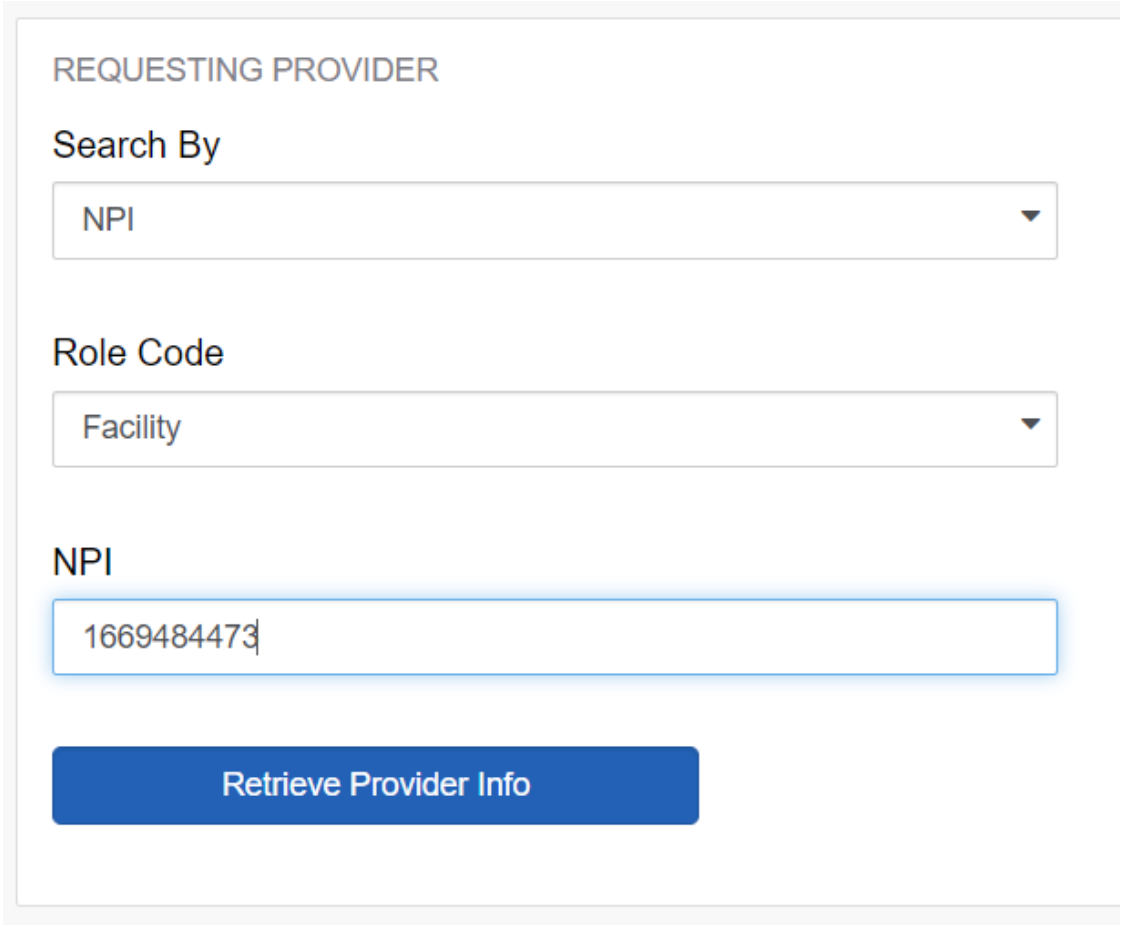
Requesting provider
1. Search by NPI or name
2. Select Role Code - provider or facility
3. Enter NPI or name
4. Click **Retrieve Provider Info**
5. Select result (if more than one result)



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.



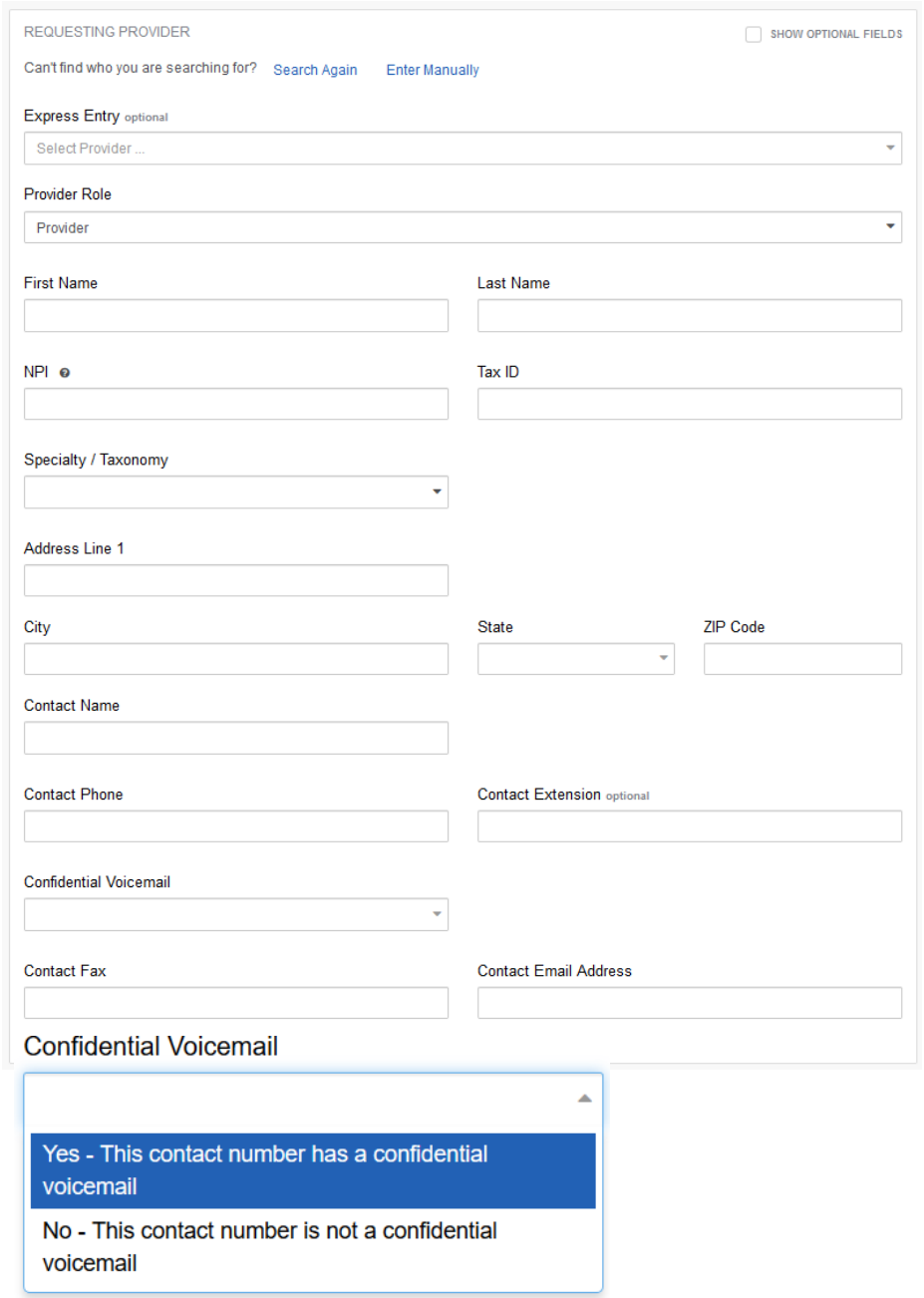
Contact information

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.



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.

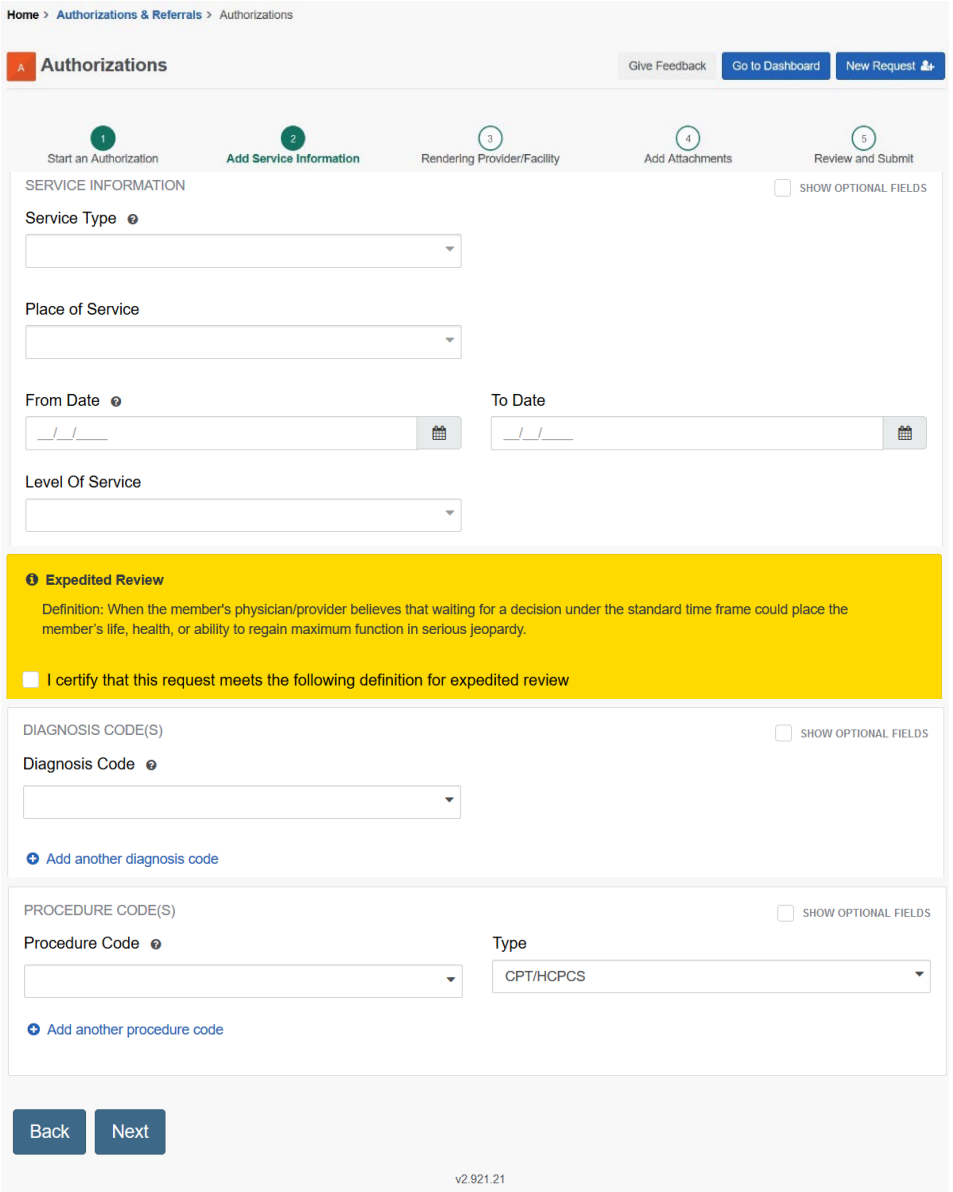
Verifying member plan.

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.



Step 3 – Rendering provider/facility

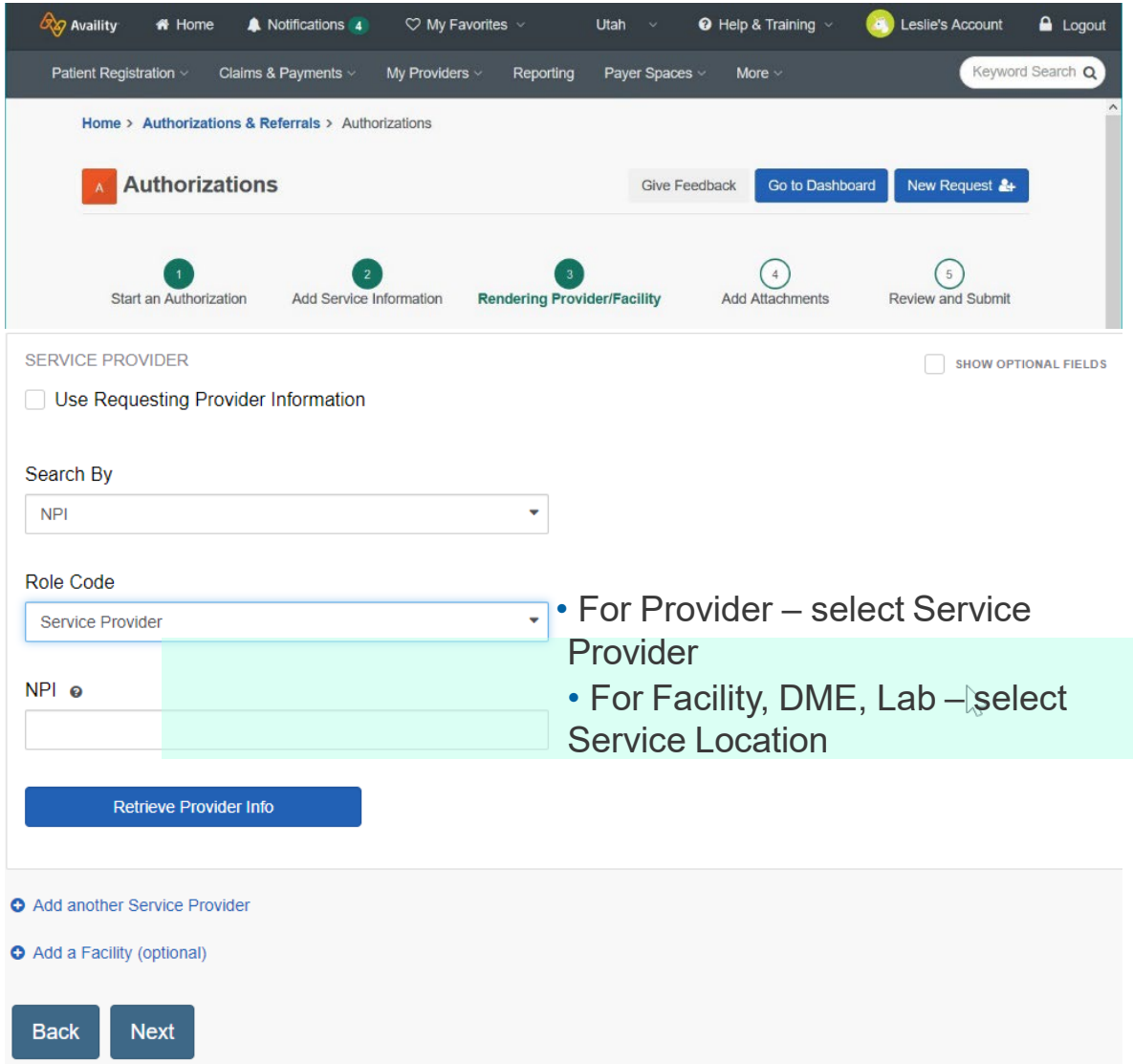
Service provider

- 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.)



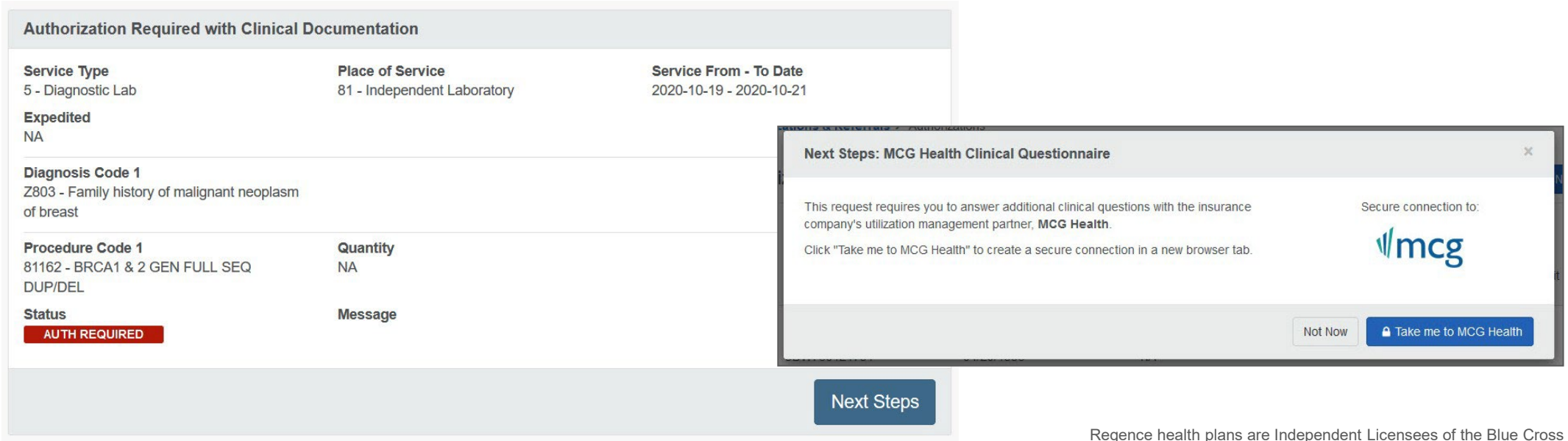
Procedure code validation

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.

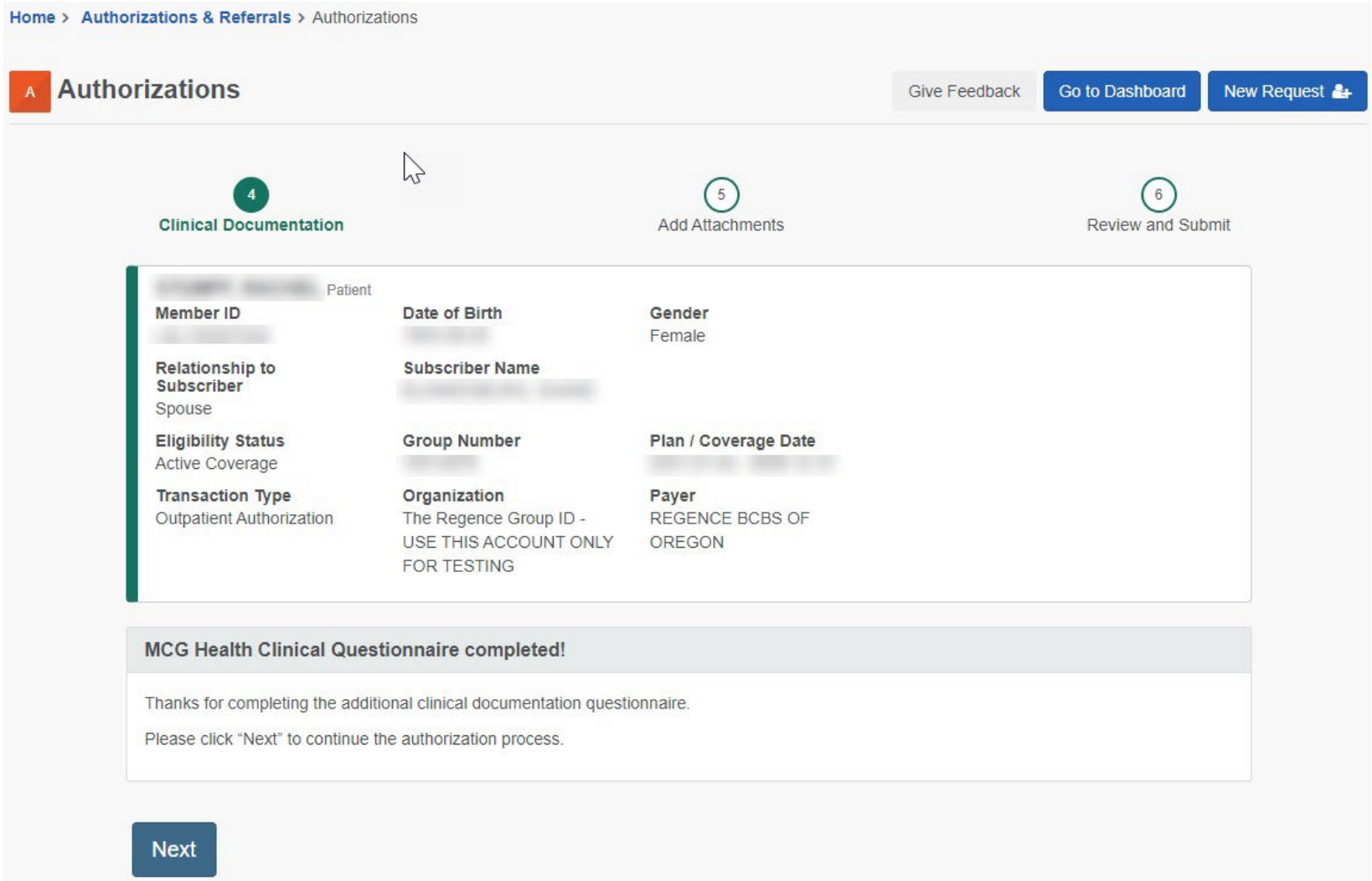
- Messaging may indicate a phone or fax number to complete the request.
- A **Next Steps** button may appear which will route the request to MCG to complete additional steps.
  - Click **Take me to MCG Health** to create a secure connection.

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



Step 4 completed - overview

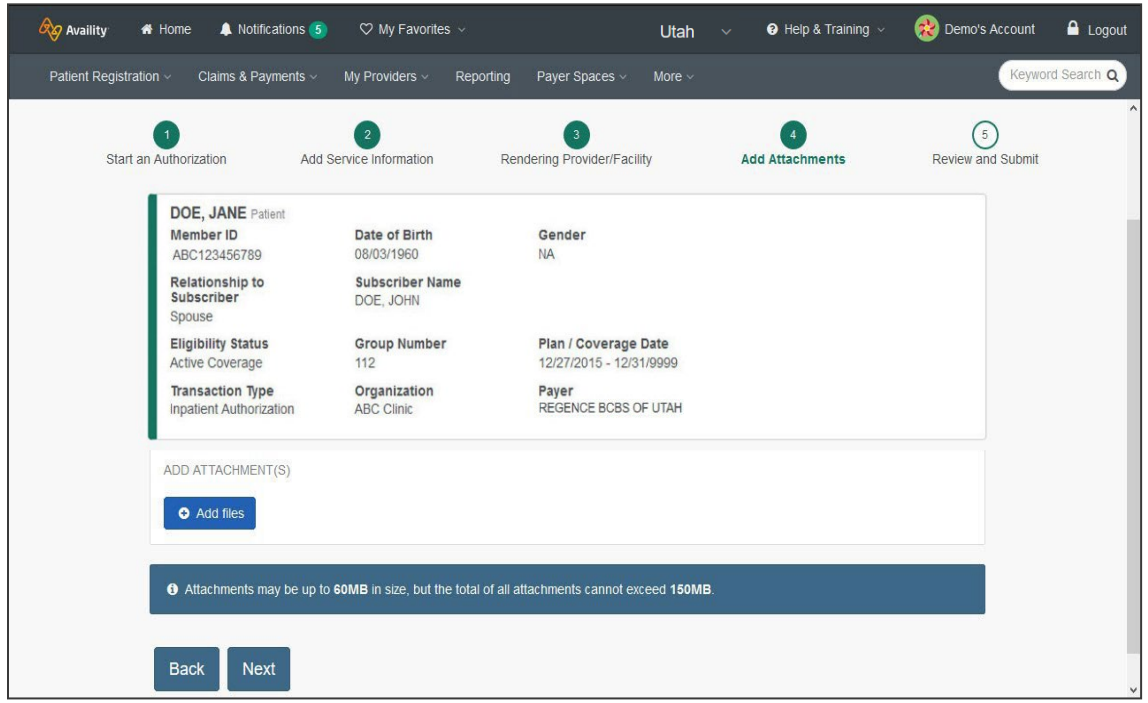
After completing the MCG Health clinical questionnaire, the next step is to add attachments.



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**.



***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: xxxxxxxxx.

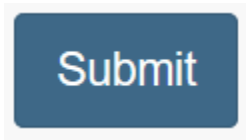
Fax documentation to us with certification/reference #.

Step 5/6 – Review and submit

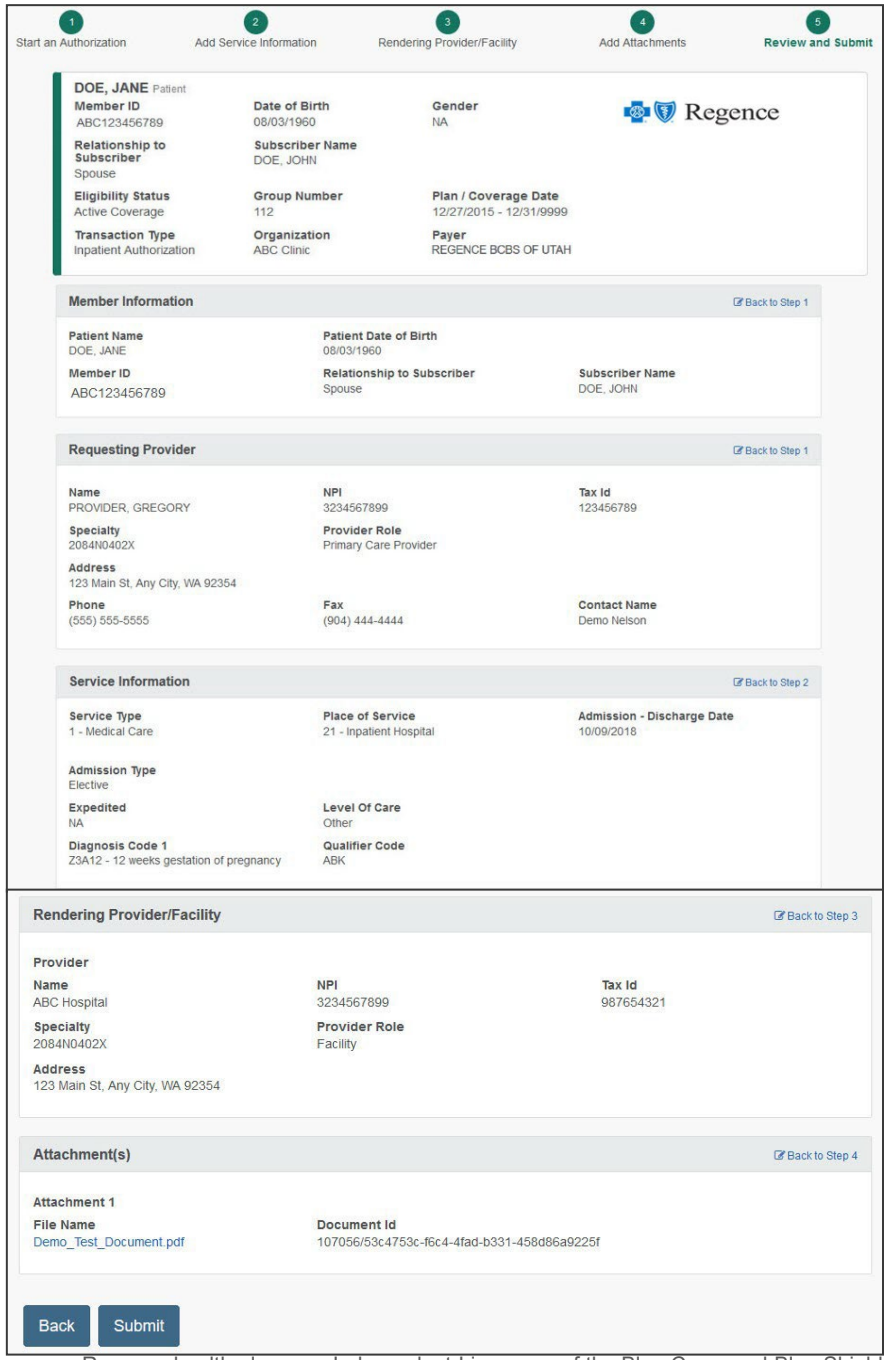
Prior to submitting the request, review all details and information entered.

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.



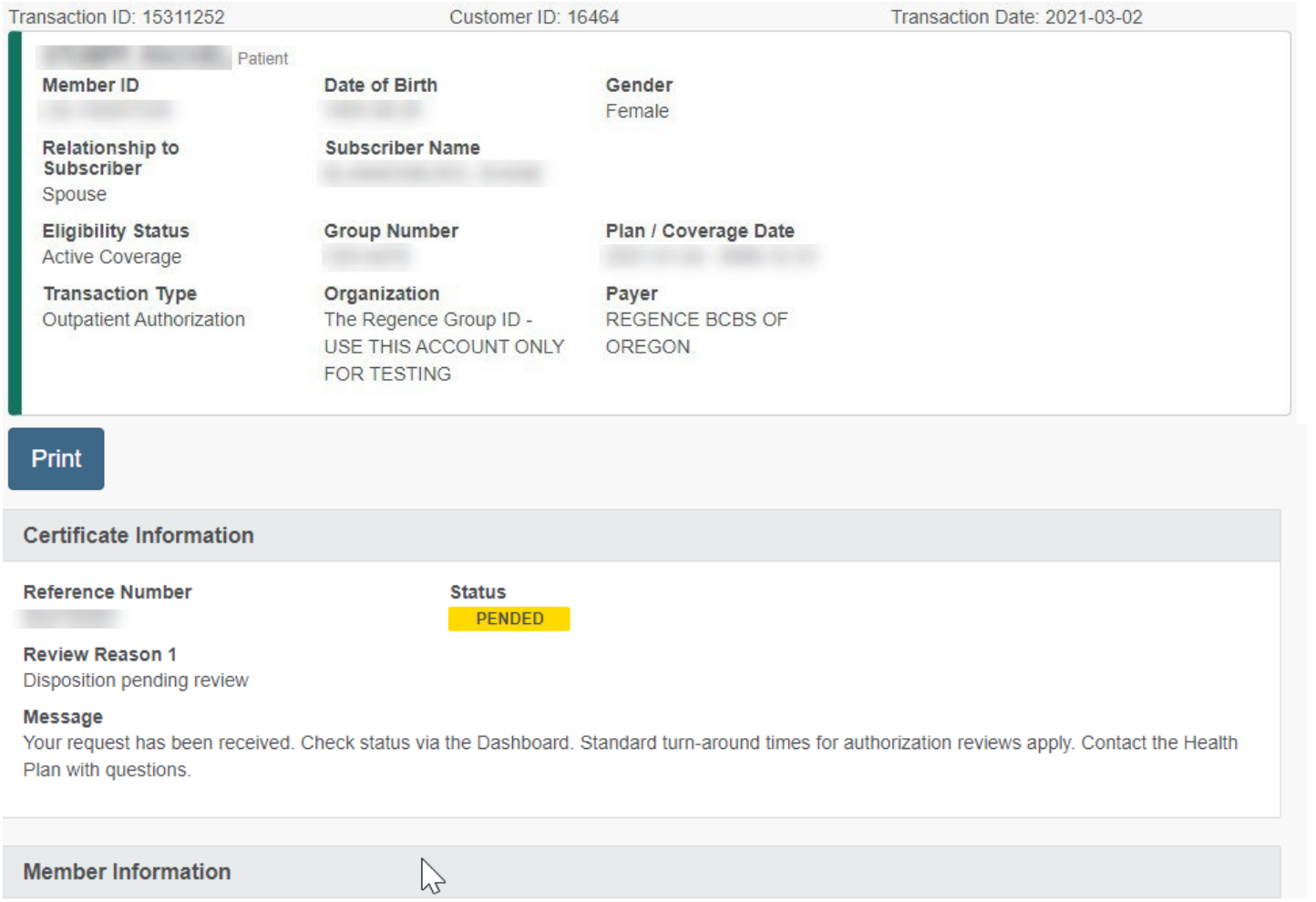
Authorization response

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.

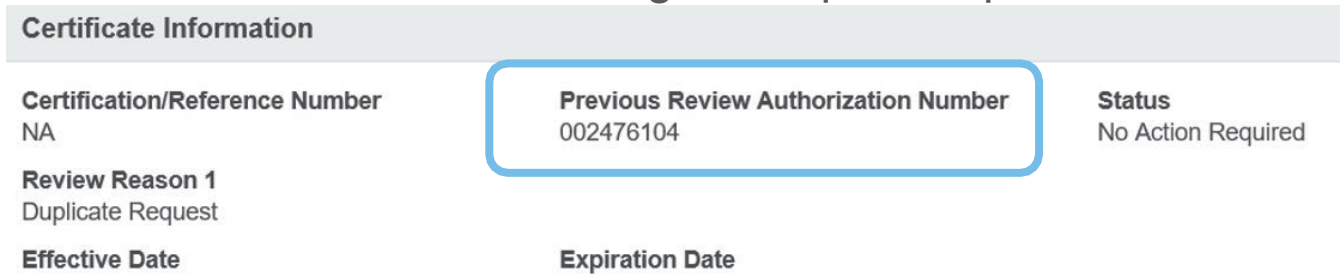


Other authorization responses

Status and review reasons

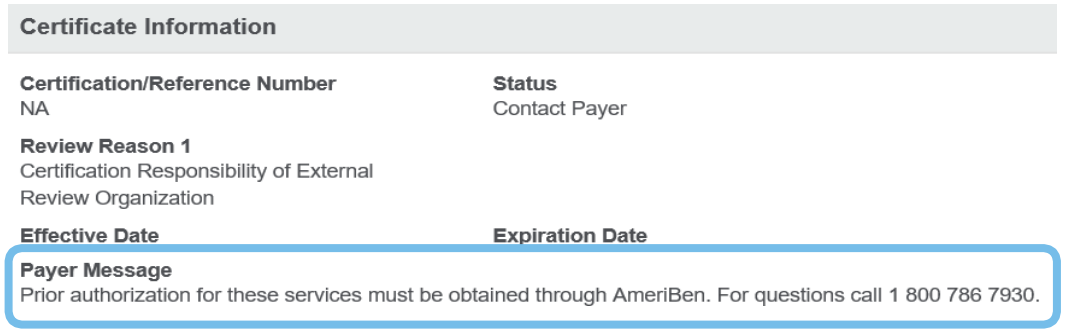
No action required - Duplicate request

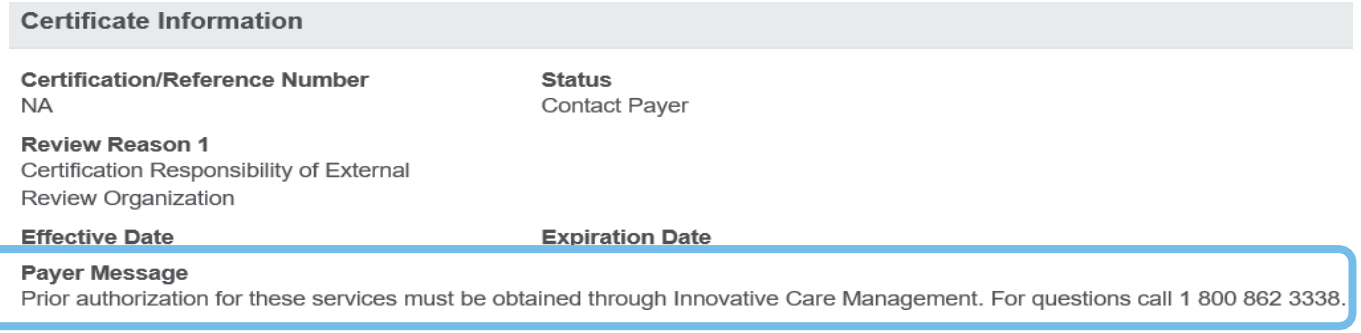
The information user entered is a duplicate to a request already received, and the certification/reference number of the original request is provided:



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.





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.

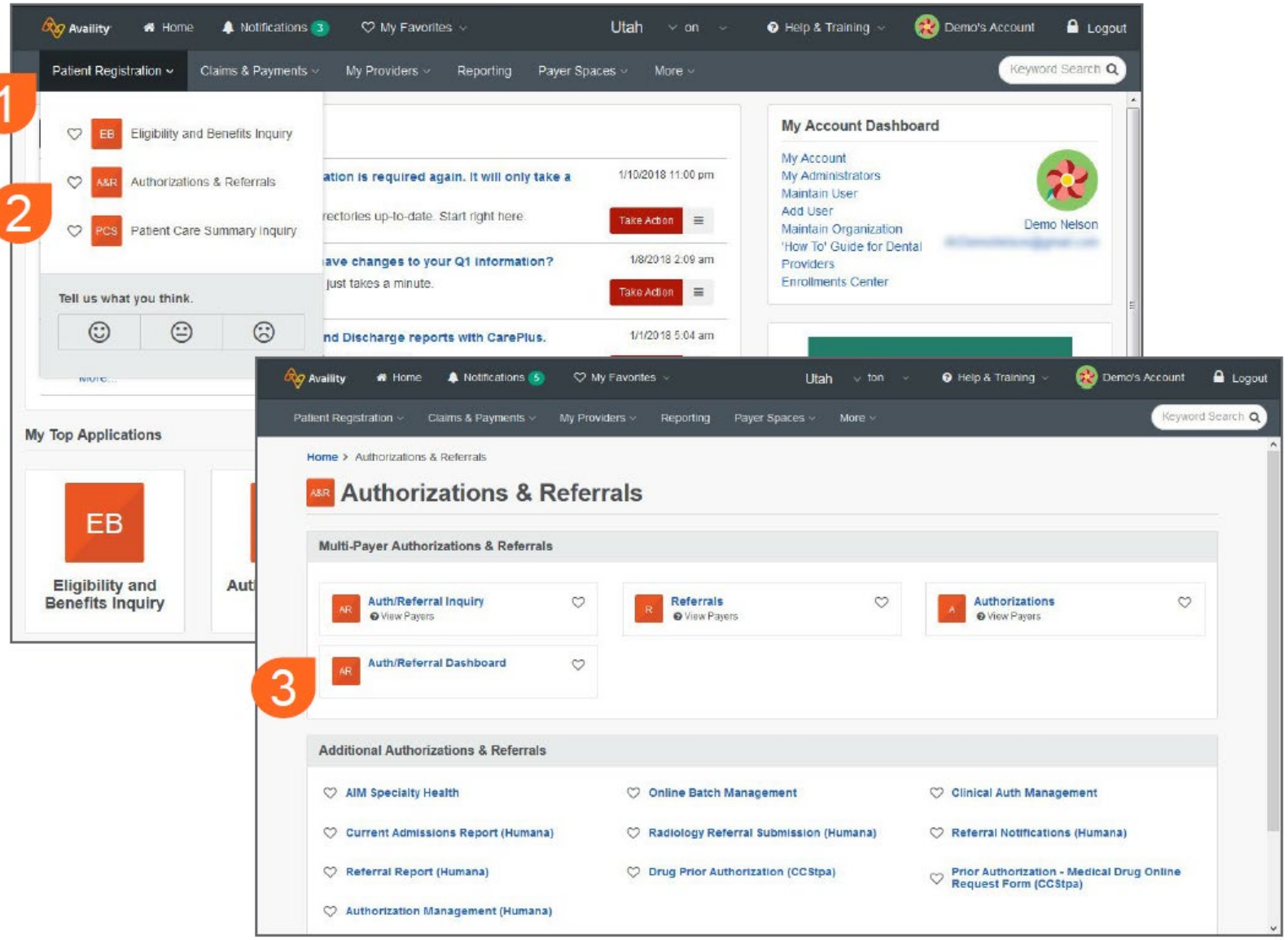
The dashboard shows:

- 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**

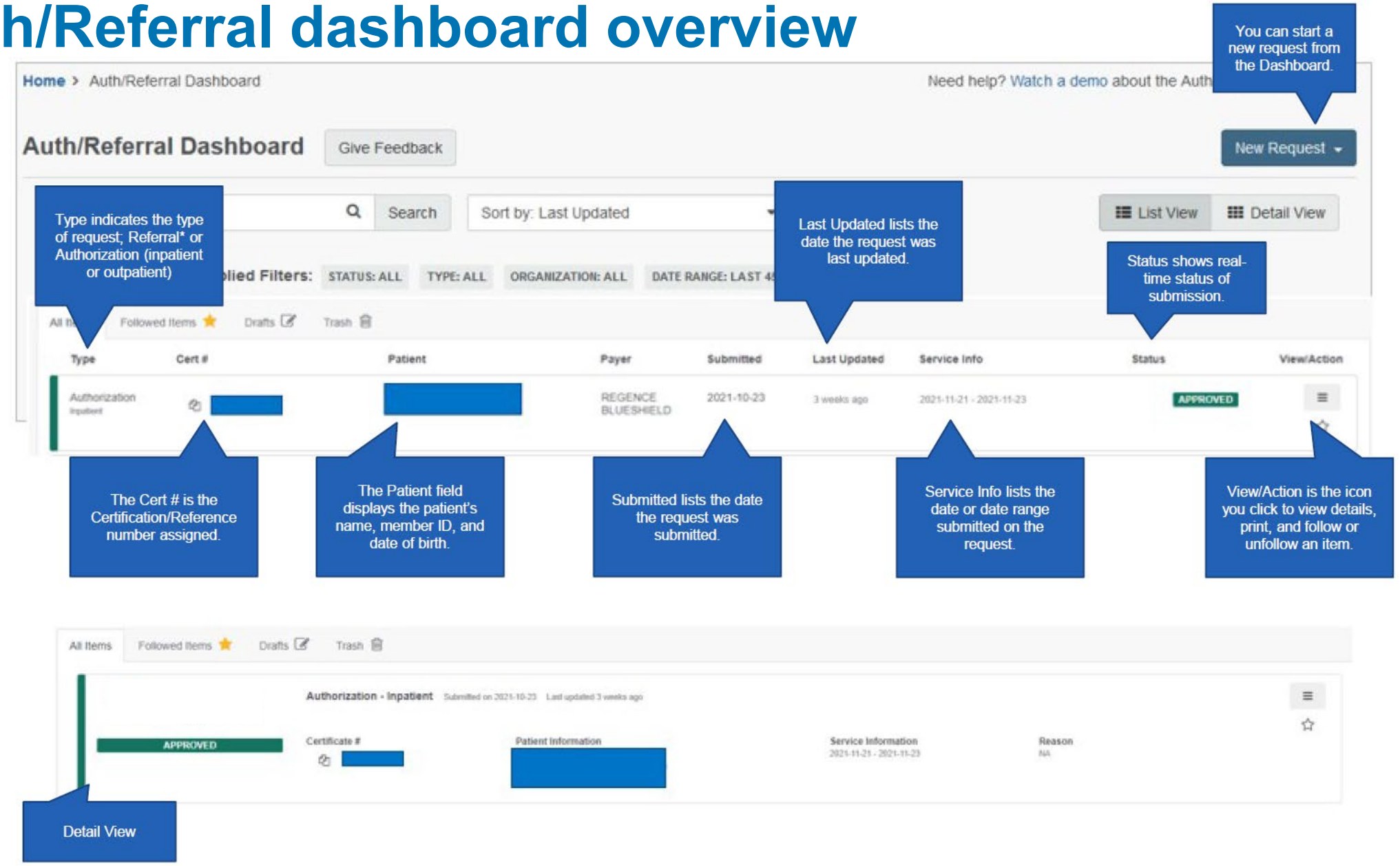
Accessing the Auth/Referral dashboard

In the Availity Essentials menu:

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



Auth/Referral dashboard overview



Regence

MCG Health

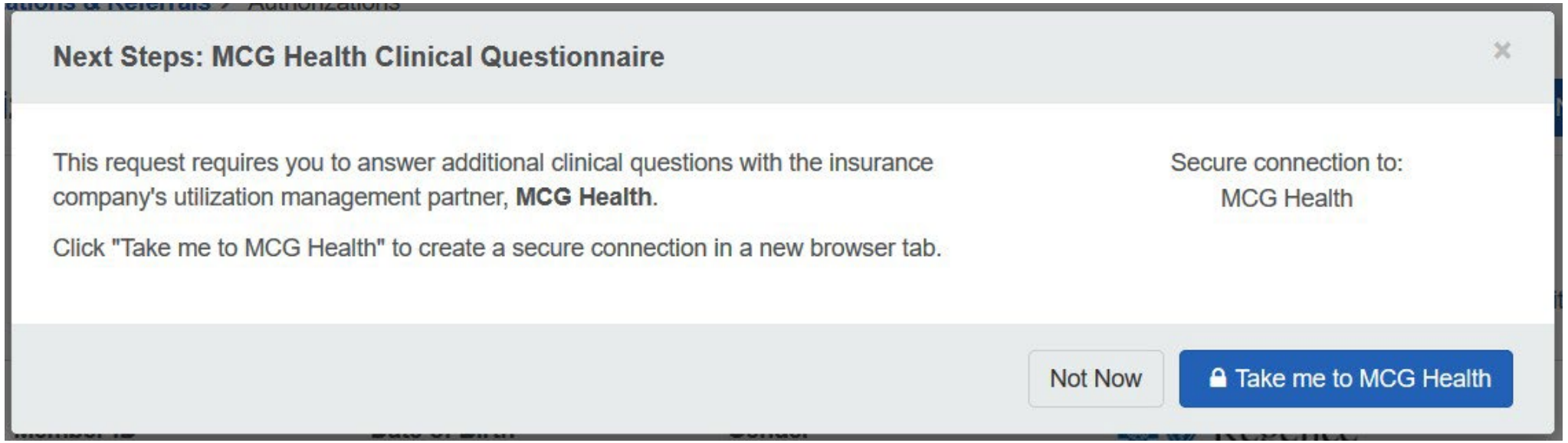
Documenting clinical information

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**

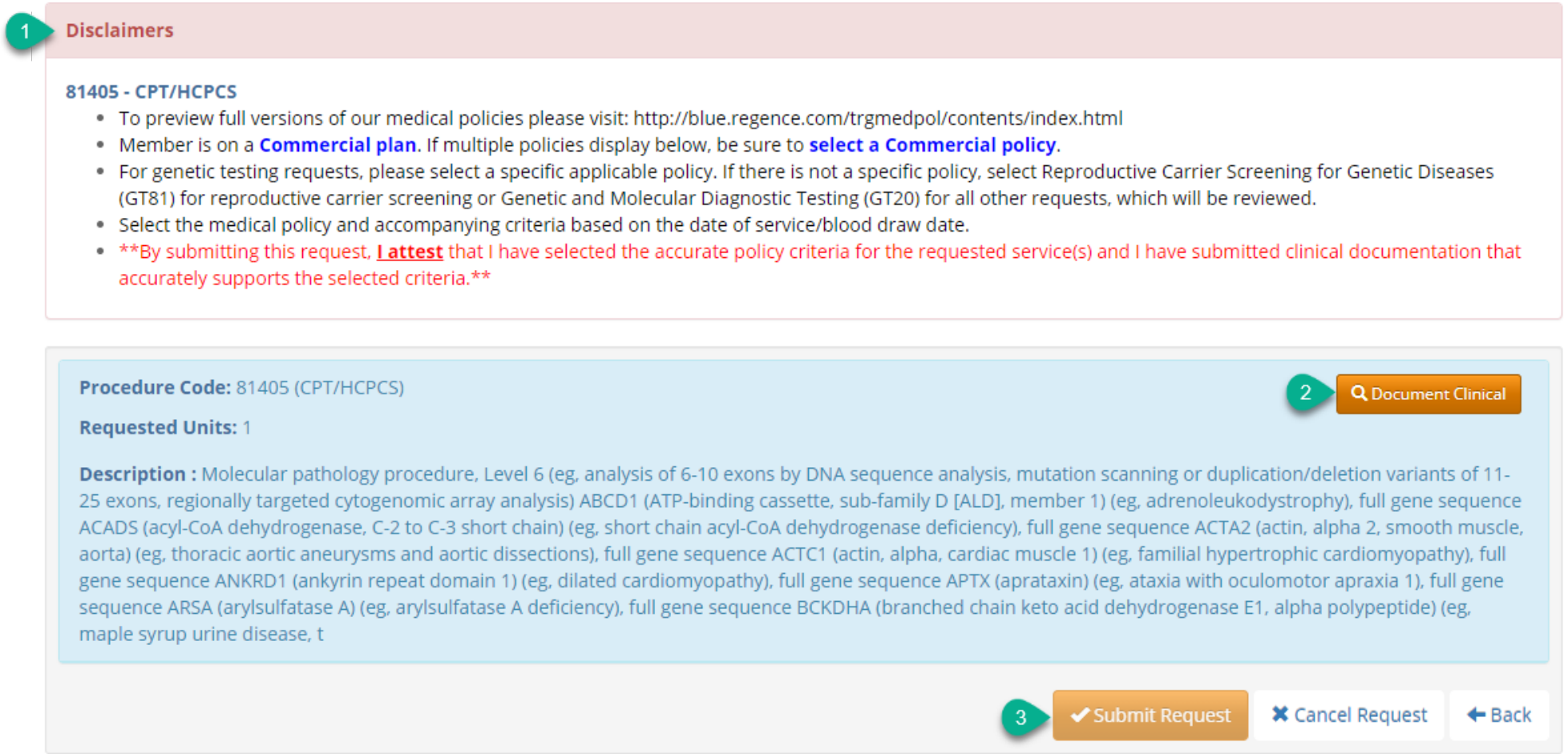


Determining Clinical Questionnaire Status.

Determining SSO values.

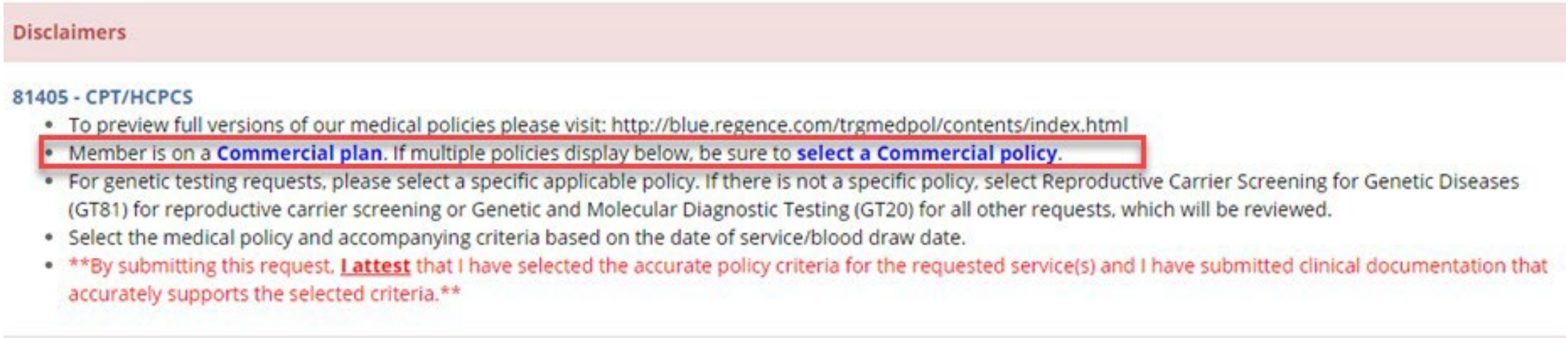
Steps to document clinical indications

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



Review disclaimers

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



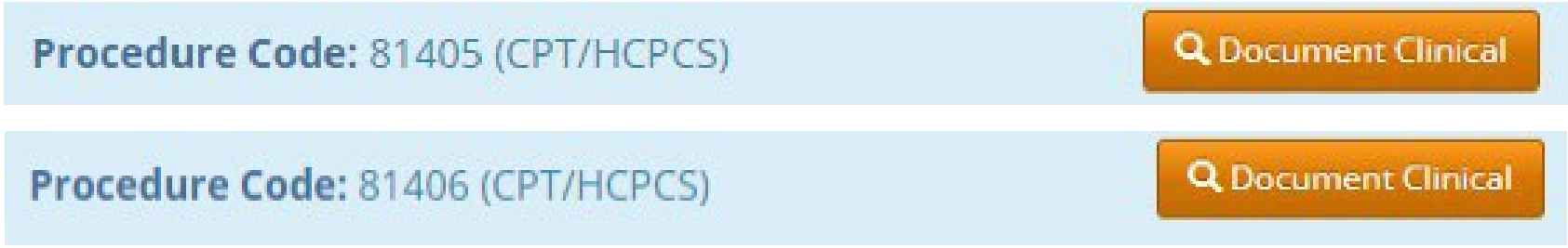
Disclaimers

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.**

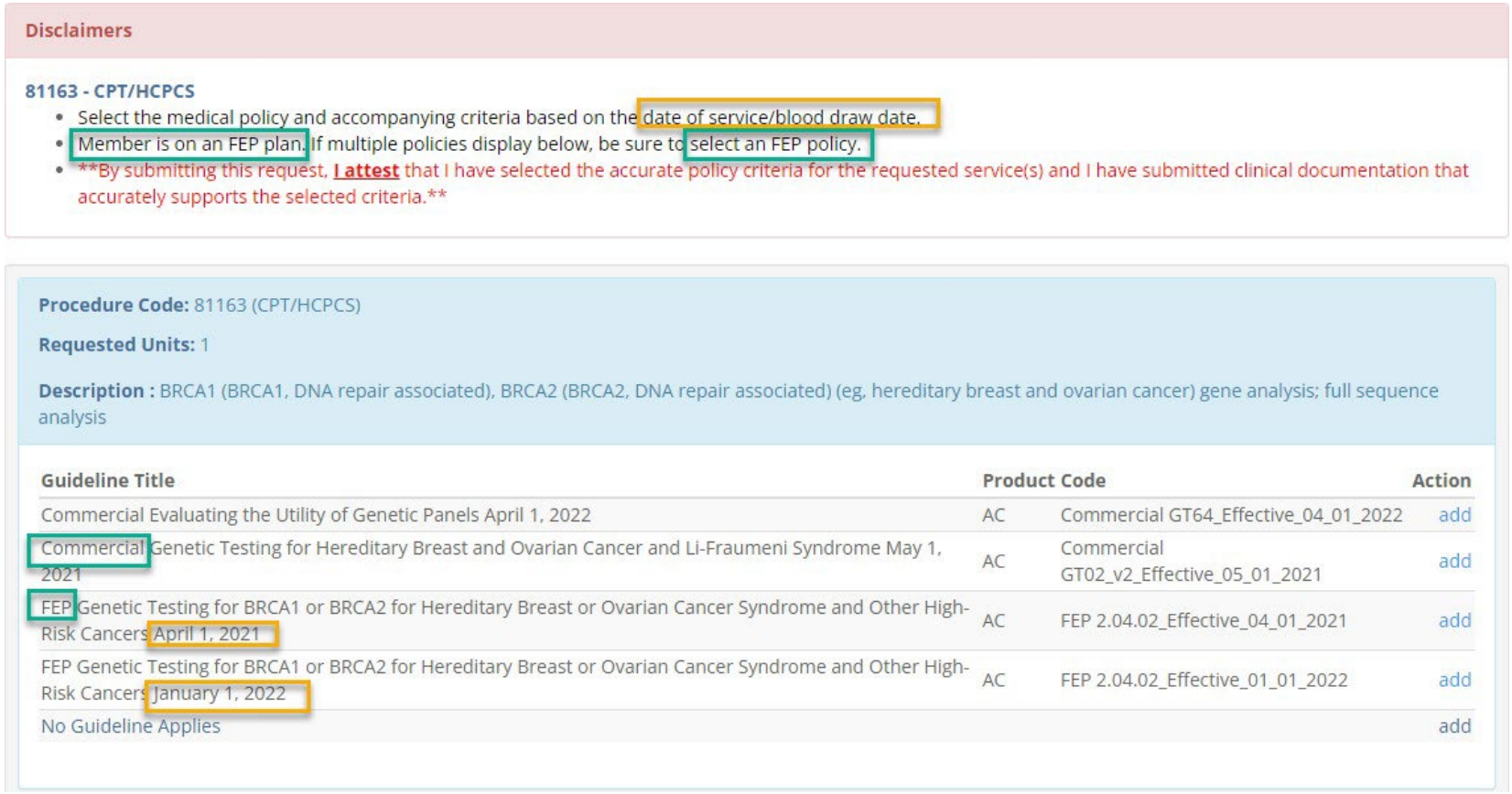
Document clinical indications for codes

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



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)

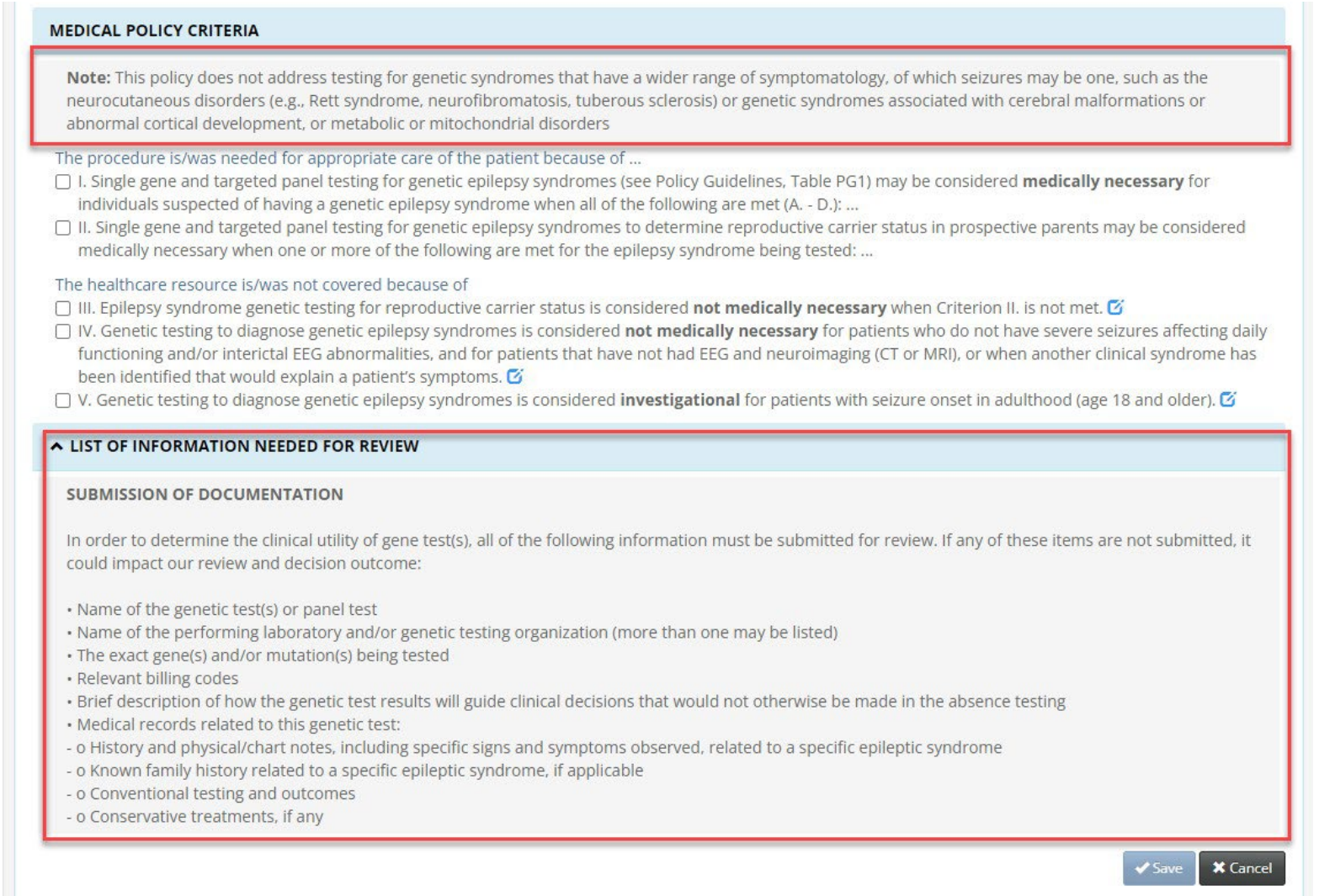
Requested Units: 1

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

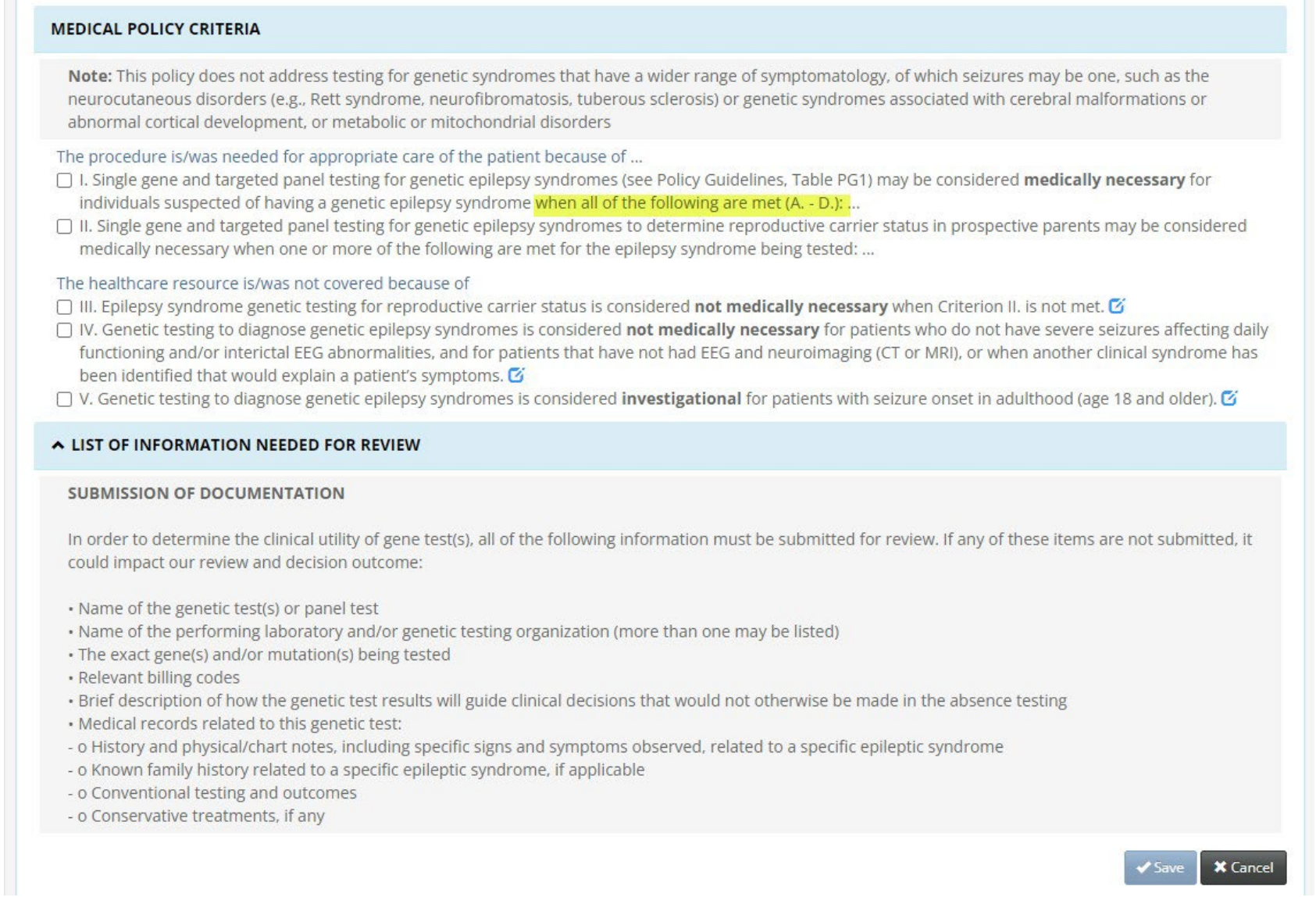
In order to determine the clinical utility of gene test(s), all of the following information must be submitted for review. If any of these items are not submitted, it could impact our review and decision outcome:

- 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



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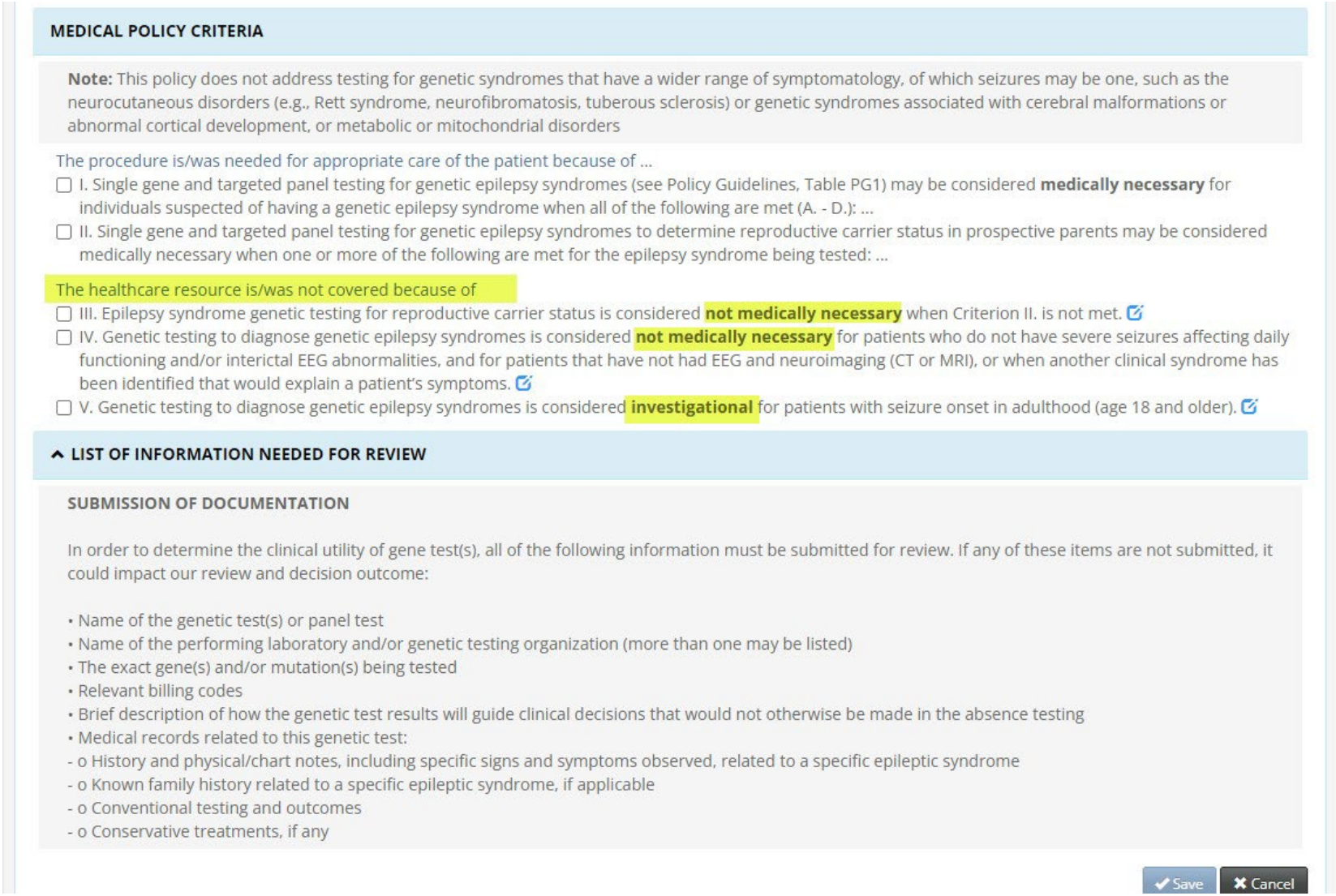
  - o Conventional testing and outcomes
  - o Conservative treatments, if any

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.



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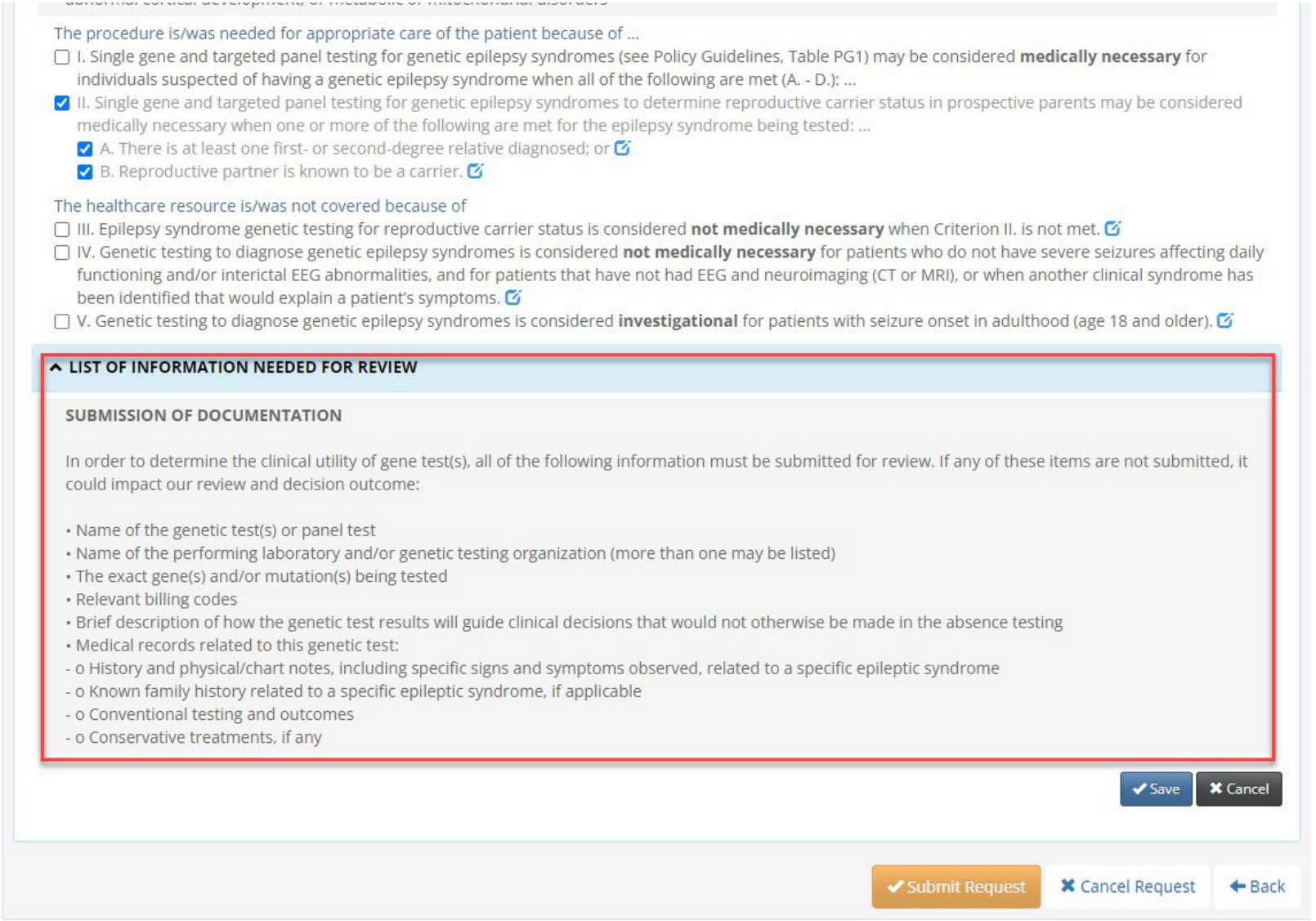
- Name of the genetic test(s) or panel test
- Name of the performing laboratory and/or genetic testing organization (more than one may be listed)
- The exact gene(s) and/or mutation(s) being tested
- Relevant billing codes
- Brief description of how the genetic test results will guide clinical decisions 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

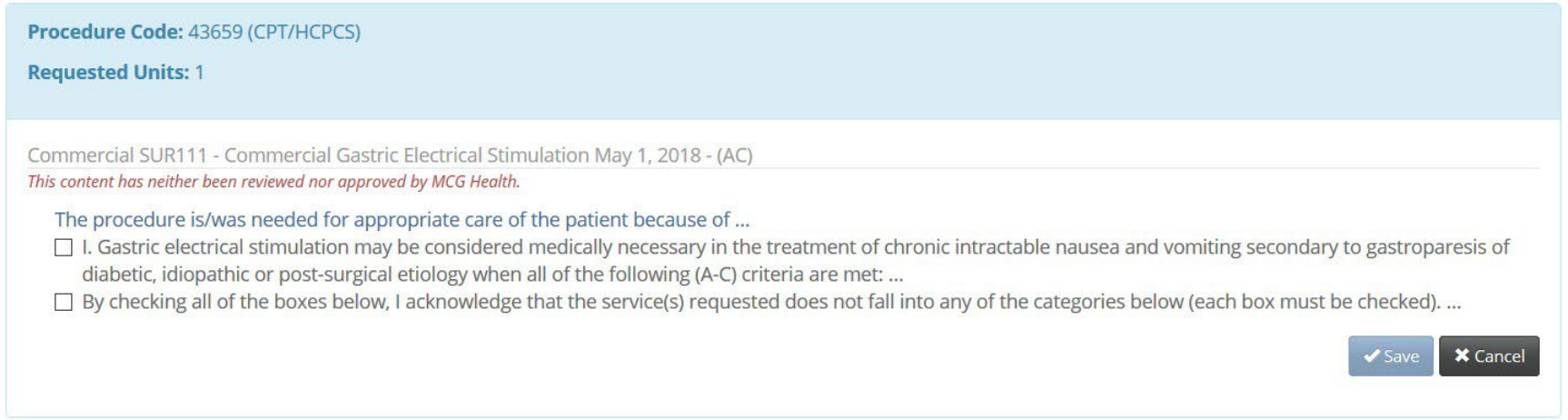
List of information needed for review

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

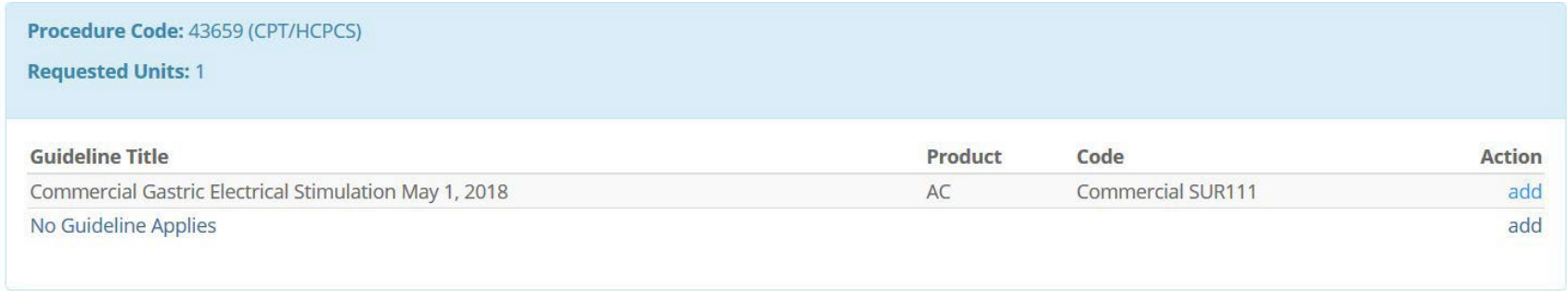


Single guideline

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

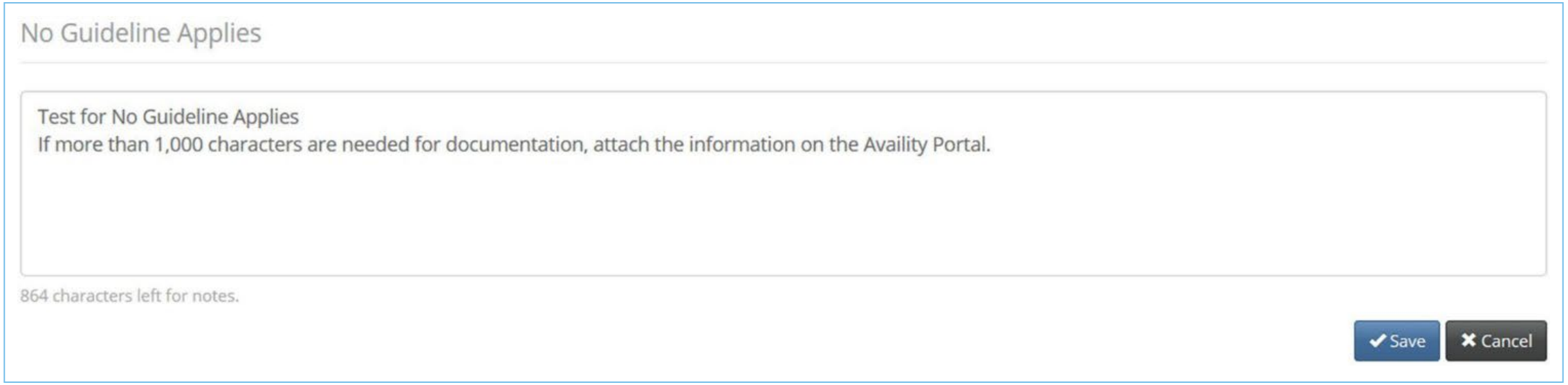


If the guideline does not apply, click **Cancel** to go back and select **add** for No Guideline Applies.



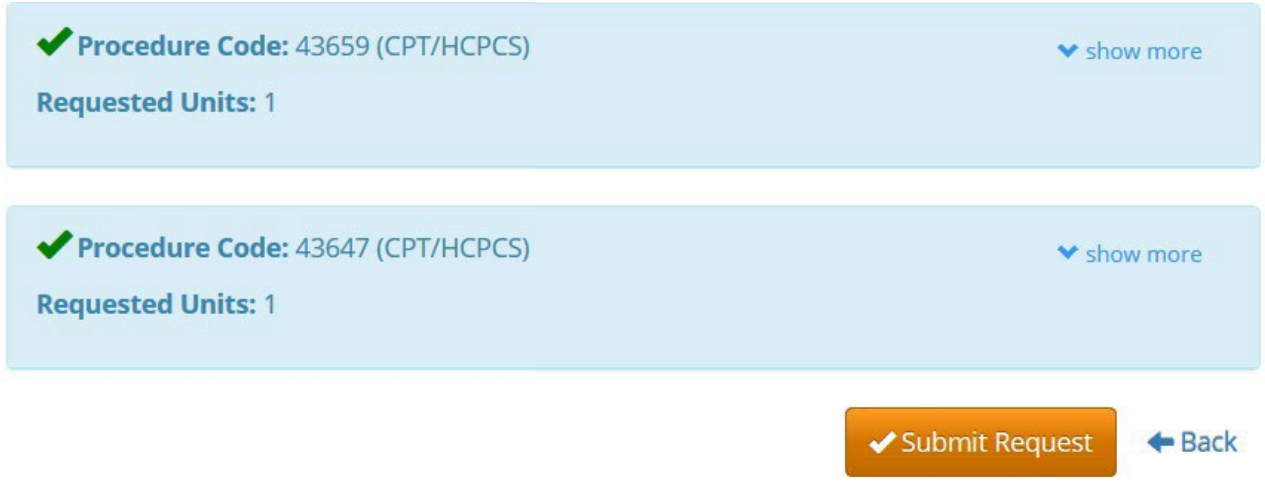
No guideline applies

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



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.



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