Specialty Referrals
User Guide

Provider.MassGeneralBrighamHealthPlan.org
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**Introduction**

Mass General Brigham Health Plan’s online provider portal Provider.MassGeneralBrighamHealthPlan.org is a web-based tool used to submit referrals for specialist visits and authorization requests for specific services and to receive real updates on the status of these requests. To submit a referral or authorization request, the patient must have active Mass General Brigham Health Plan eligibility.

The following table shows referral/authorizations that can be created in Provider.MassGeneralBrighamHealthPlan.org, with a brief description:

<table>
<thead>
<tr>
<th>Provider.MassGeneralBrighamHealthPlan.org Referrals/PA Tab</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>Allows user to create and send a real-time referral request to Mass General Brigham Health Plan.</td>
</tr>
<tr>
<td>Outpatient (Includes Observation and Surgical Day Care)</td>
<td>Allows user to create and send a real-time outpatient authorization request to Mass General Brigham Health Plan.</td>
</tr>
<tr>
<td>Admission</td>
<td>Allows user to create and send a real-time admission certification request to Mass General Brigham Health Plan.</td>
</tr>
<tr>
<td>Status</td>
<td>Allows user to search and view all Referral/Authorization responses.</td>
</tr>
</tbody>
</table>

**Helpful Hints**

- Members and providers need to verify member’s benefits and eligibility.
- There is a code checker tool so you can search by code to see authorization requirements.
- If a referral is required verify that one is in place before submitting the Prior Authorization request.
- Mass General Brigham Health Plan’s systems are updated for maintenance on the third weekend of every month starting Friday at 5:00pm until Monday morning. You will be able to enter Referrals or Authorizations during this time, but you will not receive a status report until Monday morning.
- Please contact your site User Administrator if you need access to submit authorizations.
- Error notification: If required fields have not been entered, one or more error messages will show immediately after hitting the Submit button. You will be able to return to the original screen and complete the fields.
- **Observation (OBV) or Surgical Day Care (SDC) that becomes an inpatient admission**, a separate authorization must be submitted. The provider must also indicate in the Remarks that the OBV or SDC has converted to an Inpatient Admission.
- If the **Revise Authorization** screen does not appear after clicking on **Revise Request**, user should press **Ctrl + F5** to refresh your browser.
- **Individual Consideration** - Service requests outside of the member’s benefit plan.
The following services should continue to be requested through Mass General Brigham Health Plan vendor sites:
- Sleep Studies and Sleep DME: CareCentrix
- Outpatient MRI’s, CT, and PET imaging studies: Evicore

Authorization Status

<table>
<thead>
<tr>
<th>Provider.MassGeneralBrighamHealthPlan.org</th>
<th>Edit Functionality</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROVED</td>
<td>Yes</td>
</tr>
<tr>
<td>CLOSED</td>
<td>No</td>
</tr>
<tr>
<td>MEDREVIEW</td>
<td>Yes</td>
</tr>
<tr>
<td>PEND</td>
<td>No</td>
</tr>
<tr>
<td>DENIED</td>
<td>No</td>
</tr>
</tbody>
</table>

Authorization Closure Reason Legend (most frequently used, not entire list)

- **AC – Duplicate** – More than one request for same service. Go back to original auth for revision.
- **AC – Entered in Error** – Auth closed due to error (ie. Provider used incorrect portal)
- **AC – No Prior Authorization Required** – Auths will be closed when PA is not required.
- **AC – Provider Withdrew Request** – Auth closed as provider withdrew PA request
- **AC – Redirection** – Auth closed and redirected for review by designated party (ie. ACO)
- **AC – Requires both Referral and PA** – If no referral on file, PA is closed
- **AC – Revision of Existing Authorization Required** – Do not enter new auth, revise existing auth
- **AC – Secondary Insurance, No Auth Required** – Member has other, prime, insurance. Auth not needed as secondary payer – do not submit auth.
- **AC – Status Changed** – Used for level of care changes (ie. Observation to inpatient.)
- **AC – Submit to Evicare** – Auth must be submitted to eviCore for review and will be closed
- **AC – Submit to Optum** - Auth must be submitted to Optum for review and will be closed
- **AC – Template/Service Mismatch - See User Guide and Resubmit** – the service requested was placed on the wrong template and was closed. New auth needed.
Logging into Provider.MassGeneralBrighamHealthPlan.org to Submit a Referral Request

   - If you encounter issues with login, searching for an authorization or attaching a file in Provider.MassGeneralBrighamHealthPlan.org, please contact Mass General Brigham Health Plan Provider Customer Service department at prweb@allwayshealth.org.
   - Single-site access or multi-site access exists. Users with multi-site access may update the site for which they are submitting the request by selecting it from the current site drop down.

2. Click on Submit an auth.
Select Authorization/Referral Type: Specialty Referral

Enter the member ID or name and then press the Search button to select an eligible member. This request cannot be submitted if you do not search for and select a member.

Patient Search (Member ID/Name) [Search]

Requesting Provider: FAMILY CARE ASSOCIATES, LLC

Contact Name

Contact Phone

Requested Service [Select One]

Servicing Facility (Name/NPI) [Search]

Contact Name

Contact Phone

Diagnosis [Search]

Procedure Code [Search]

Service start date: 12/15/2022

Service end date: 12/15/2023

Remarks (limited to 255 characters)

Submit

Required fields are denoted with this small sphere (●) next to the field name
Creating a Specialty Referral Request

1. **Authorization/Referral Type**: select Specialty Referral.

2. **Patient Search**: Click Search.

   A box will pop up. Enter the **Member ID** and **Last Name** and click **Search**. Click on the correct member under the Member Search Results.

3. **Requesting Provider**: Will auto populate with Current Site name. Users with access to multiple sites can update selection in the Current Site fields at the top of the page.

4. **Contact Name and Phone Number**: Will auto populate based on user login, however, both fields can be edited.

5. **Requested Service**: Select **Consultation** from drop down.

6. **Servicing Facility/Provider**: Enter the **Individual doctor**, **Group** or **NPI** and click **Search**. Click **Select** next to the appropriate provider. If the individual provider is associated with more than one group, be sure to select the correct provider site to ensure claims payment.

*Effective dates in red indicate member is termed.*
7. **Contact Name and Phone Number**: Enter contact information. (Area code is required).

8. **Diagnosis**: Enter description or ICD10 code (if COVID related, search for applicable diagnosis/ICD 10 code), click **Search**, and select appropriate diagnosis from the list. Up to six diagnoses can be entered, however, the primary diagnosis should be entered first.

9. **Procedure Code**: Enter any consultation code in the range 99201 – 99215. The exact consult code that the specialist will be submitting on their claim is not required.

10. **Units/Visits**: This field will appear after a consultation code has been selected.
   a. Enter the number of requesting visits/days/units.

11. **Start Date and End Date**: Enter requested date range.

12. **Remarks**: Use for brief clinical, modifiers, and other information. There is a 255-character limit.

13. **Submit**.
Response Screen

- Once you complete an authorization, you will receive a real-time response.

If your submission request doesn’t provide a real-time response, the following message will be displayed:

*Your request has been received and will be processed at a later time. Please check back in 4 hours or by the following morning to see your updated status. In the interim, you can fax your clinical notes to us at 617-586-1700. Please include the date/time of your online submission on your fax cover sheet. Otherwise, you can wait until the request is in our system and upload clinical notes at that time.*

Authorizations & Referrals Viewer

This cannot be revised because the status is not MEDREVIEW or APPROVED

<table>
<thead>
<tr>
<th>Authorization/Referral ID</th>
<th>Member ID</th>
<th>Member Date Of Birth</th>
<th>Product</th>
<th>Member PCP</th>
<th>Referral By</th>
<th>Referred To</th>
<th>Inpatient/Outpatient</th>
<th>Diagnosis Code</th>
<th>Diagnosis Description</th>
<th>Authorization/Referral Status</th>
<th>Authorization/Referral Date</th>
<th>Service Start Date</th>
<th>Service End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>22348R00000</td>
<td>1007010070</td>
<td>01/01/1954</td>
<td>MEDICARE ADVANTAGE</td>
<td></td>
<td>FAMILY CARE ASSOCIATES, LLC (1417969817)</td>
<td>BRIGHAM AND WOMEN’S HOSPITAL (1790717650)</td>
<td>Inpatient</td>
<td>N50.02</td>
<td>Scrotal pain</td>
<td>PENDING</td>
<td>12/14/2022</td>
<td>12/19/2022</td>
<td></td>
</tr>
</tbody>
</table>

Authorization/Referral Service Lines

<table>
<thead>
<tr>
<th>Line</th>
<th>Status</th>
<th>Code</th>
<th>Code Type</th>
<th>Modifier</th>
<th>Description</th>
<th>Total Units</th>
<th>Used Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PENDING</td>
<td></td>
<td></td>
<td></td>
<td>Inpatient Stay</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Authorization/Referral Supporting Documentation

<table>
<thead>
<tr>
<th>Description</th>
<th>Document</th>
<th>Size</th>
<th>Uploaded</th>
</tr>
</thead>
</table>

- Click on Submit Document button to upload clinical information.
- Click on Choose File to search and attach a file. Enter a description and click Upload.
Click on Fax Document if you are unable to submit your documentation electronically. This will generate a fax cover sheet referencing the corresponding authorization number of your request and other pertinent information. You will need to print this cover sheet and include this as part of your fax.

Once a document is attached, it will appear at the bottom of the authorization viewscreen. More documents may be attached at any time.

- Please note: When submitting clinical information via fax (selecting the fax document button) the upload will be automatically named with the Auth ID#, Date and Time.
# Authorizations & Referrals Viewer

**Revised Request**

## Authorizations/Referral Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization/Referral ID</td>
<td>22348R000000</td>
</tr>
<tr>
<td>Member ID</td>
<td>1007010070</td>
</tr>
<tr>
<td>Product</td>
<td>MEDICARE ADVANTAGE</td>
</tr>
<tr>
<td>Referred By</td>
<td>FAMILY CARE ASSOCIATES, LLC (1417969817)</td>
</tr>
<tr>
<td>Member Date Of Birth</td>
<td>01/01/1954</td>
</tr>
<tr>
<td>Member PCP</td>
<td></td>
</tr>
<tr>
<td>Referred To</td>
<td>BRIGHAM AND WOMEN'S HOSPITAL (1790717650)</td>
</tr>
<tr>
<td>Inpatient/Outpatient</td>
<td>Inpatient</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>N50.82</td>
</tr>
<tr>
<td>Diagnosis Description</td>
<td>Scrotal pain</td>
</tr>
<tr>
<td>Authorization/Referral Status</td>
<td>APPROVED</td>
</tr>
<tr>
<td>A - General Medicine</td>
<td></td>
</tr>
<tr>
<td>Service Start Date</td>
<td>12/14/2022</td>
</tr>
<tr>
<td>Service End Date</td>
<td>12/19/2022</td>
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<th>Line</th>
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<th>Total Units</th>
<th>Used Units</th>
</tr>
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<tbody>
<tr>
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<td>Inpatient Stay</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
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</table>

## Authorization/Referral Supporting Documentation

<table>
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<tr>
<th>Description</th>
<th>Document</th>
<th>Size</th>
<th>Uploaded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicals</td>
<td>UserGuidelinepatient_2.7.2022.pdf</td>
<td>806KB</td>
<td>12/14/2022 11:40 AM</td>
</tr>
</tbody>
</table>

[Submit Document] [Fax Document]
Revisions

Edit an Existing Referral Request

- A Referral request may only be edited when the referral or authorization is in the Approved or Medreview status.
- On the main Provider.MassGeneralBrighamHealthPlan.org screen, go to Authorization → View auth status.

- Under View Authorizations & Referrals By, use the Member ID or Authorization/Referral ID and click Go.
  - If Member ID is selected, choose the specific authorization number you want to revise and click View.
  - If Authorization/Referral ID is selected, it will automatically bring you to the authorization.
▪ Click on Revise Request. If the Revise Authorization screen does not appear, user should press CTRL + F5 to refresh the browser.
▪ Enter additional requested units, add a procedure, and/or enter remarks.
▪ Click on **Submit Revision Request**.

**Revise Authorization**

**22348R00000**

**Add Units**

0121  Room & Board - SEMI-2BD Med/Surg/Gyn  0

**Add Procedures**

**Remarks:**

![Submit Revision Request]

**Referral Revision Rules**

▪ Only the following fields can be edited in a Referral:
  ○ Requested units
  ○ Remarks
▪ Before you begin, print the approved transaction to have a record of the services and date range already authorized.
▪ When requesting additional units (visits), the original units must be deleted in the Requested Units field and populated with **only** the additional units requested.
**View Authorizations**

- Click on **Authorizations** and choose **View auth status** from the drop down.

- User may view an authorization by:
  - Authorization or Referral ID
  - Viewing Authorization and Referrals for a member
  - Viewing Authorization and Referrals for this site