Mass General Brigham
Health Plan

Outpatient Authorization User Guide

Provider.MassGeneralBrighamHealthPlan.org

Table of Contents

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:

Provider.MassGeneralBrighamHealthPlan.org Referrals/PA Tab	**Brief Description**
Referral	Allows user to create and send a real-time referral request to Mass General Brigham Health Plan
Outpatient (Includes Observation and Surgical Day Care)	Allows user to create and send a real-time outpatient authorization request to Mass General Brigham Health Plan
Admission	Allows user to create and send a real-time admission certification request to Mass General Brigham Health Plan
Home Health Care	Allows user to create and send a real-time Home Health Care request to Mass General Brigham Health Plan

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 admissio**n, a separate authorization must be submitted. The provider must also indicate in the Remarksthat 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

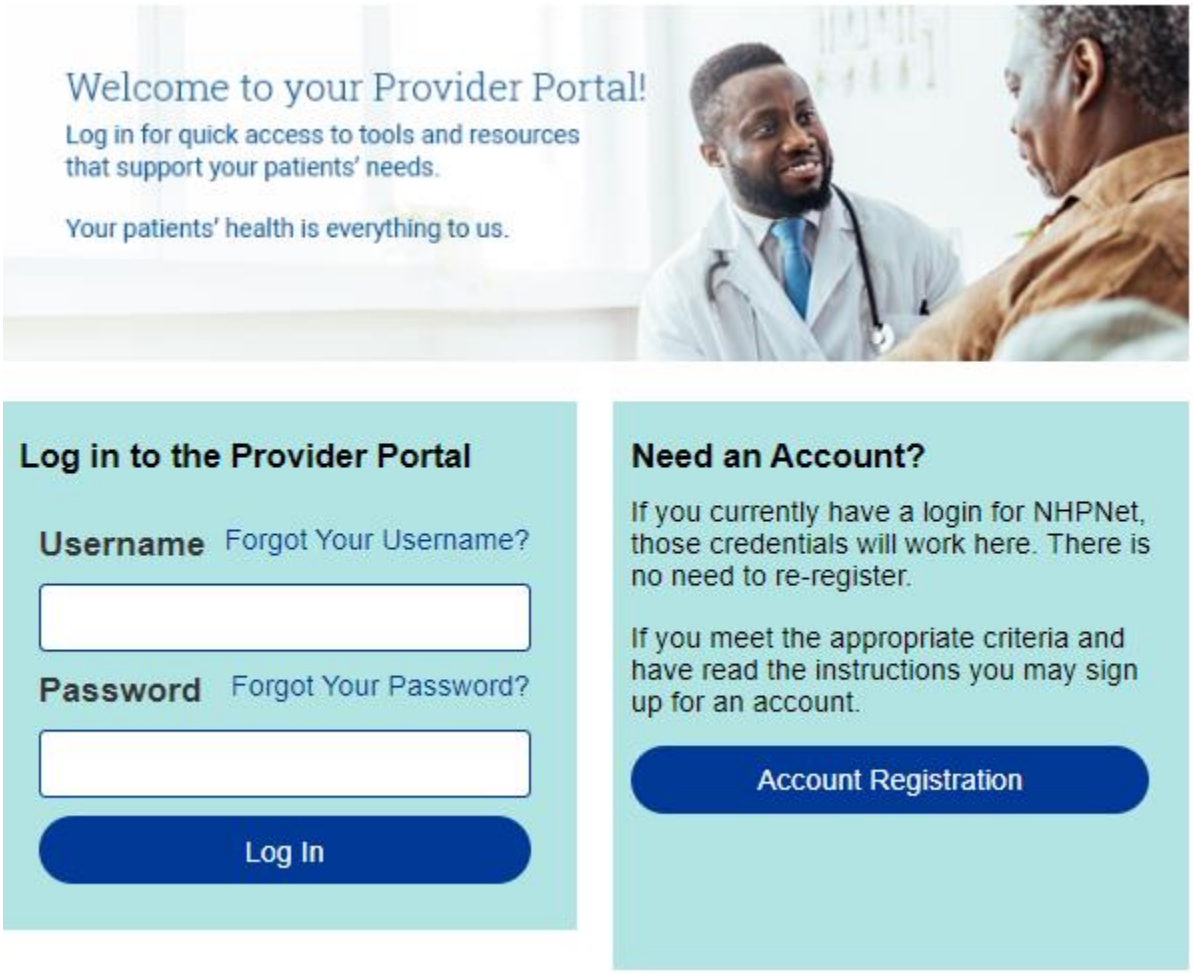
Provider.MassGeneralBrighamHealthPlan.org	Edit Functionality
APPROVED	Yes
CLOSED	No
MEDREVIEW	Yes
PEND	No
DENIED	No

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

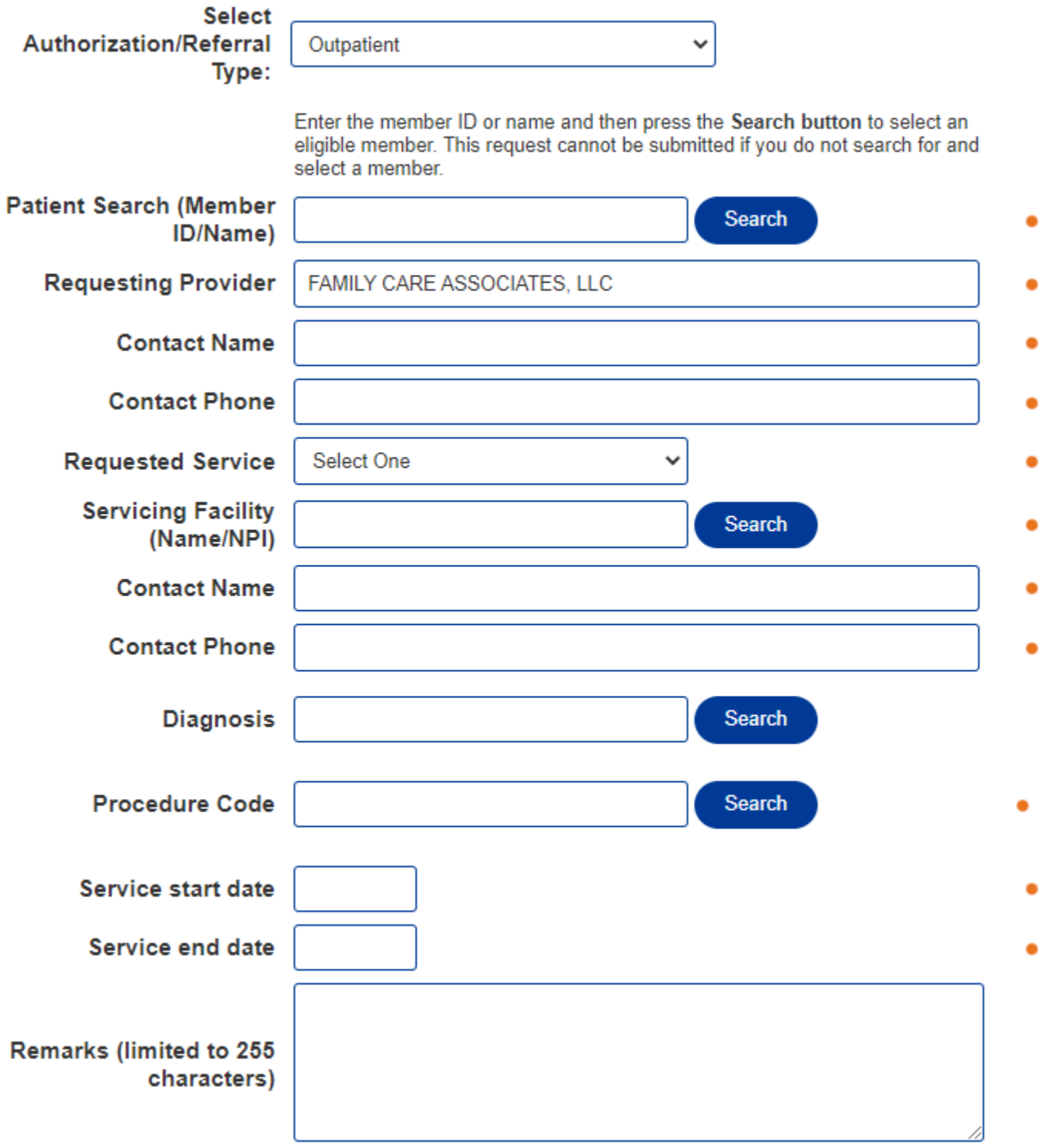
- **AC – Duplicate** – More than one request for same service. Go back to original auth for revision.
- **AC – Entered in Error** – Auth closed due to error (ie. Provider used incorrect portal)
- **AC – No Prior Authorization Required** – Auths will be closed when PA is not required.
- **AC – Provider 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 Evicore** – 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 Authorization Requests

1. Log onto the Mass General Brigham Health Plan Provider Portal: https://provider.massgeneralbrighamhealthplan.org.
    - 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**.



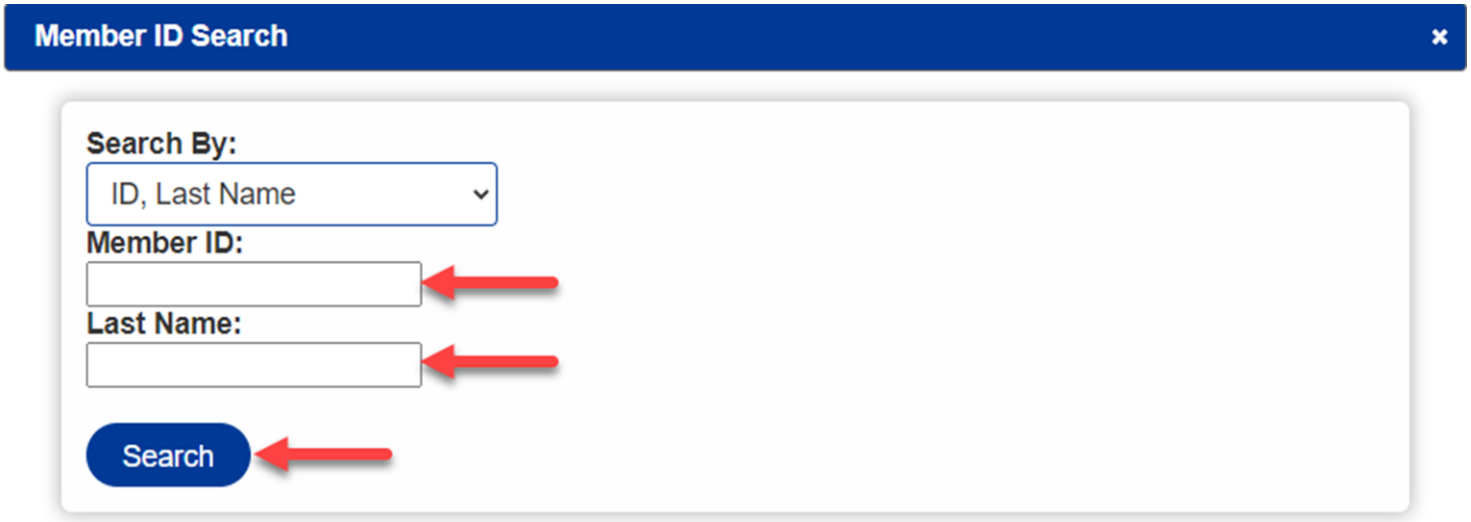
Required fields are denoted with this small sphere (●) next to the field name.

Creating an Outpatient Request

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

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**.



Member Search Results

Name	Date of Birth	Gender	Member ID	Valid From	Valid Until
LHASO, JOHN	1/1/1954	Male	1007010070	10/1/2022	12/31/2078

*Effective dates in **red** indicate member is termed.

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 appropriate service type from drop down. Please note the newly added services (bolded with asterisk*) in the drop down menu.

Requested Service	Comments
Acupuncture	Prior Authorization is required for greater than 20 visits for certain My Care Family (MVACO) members ONLY
Chiropractic	Mass General Brigham Health Plan Commercial and Qualified Health Plans with an unlimited chiropractic visit benefit will require prior authorization for visits beyond 20 visits. My Care Family (MVACO) members ONLY will continue to have a benefit limit of 20 chiropractic visits within the benefit period
Cardiac/Cardiac Imaging	For all Cardiac Imaging requests, submit auth request to Mass General Brigham Health Plan
Dental Accident	
DME Enteral Product*	Enteral product requests require the completed Combined MassHealth Managed Care (MCO) Medical Necessity Review Form be attached to the authorization in Mass General Brigham Health Plan once an authorization number has been received.
DME Purchase	• Enter modifiers in the Remarks of the authorization. • Attachment of physician prescription and clinical documentation to Mass General Brigham Health Plan authorization is required.
DME Rental	• Enter modifiers in the Remarks of the authorization • Attachment of physician prescription and clinical documentation to Mass General Brigham Health Plan authorization is required.
Early Intensive Behavioral Intervention* **(formerly known as EI ABA or EI ABT)**	**Effective 10/1/2021** **Mass Health (My Care Family) or Commercial Members:** For members under the age of 3 who qualify for EIBI, services are reviewed by Mass General Brigham Health Plan in coordination with our behavioral health partner. For members over the age of 3: Adaptive Behavioral Treatment (ABT) or Applied Behavioral Analysis (ABA) services are reviewed by our behavioral health partner. Please submit request directly to Optum.
Experimental and/or Investigational*	For services noted as Experimental/Investigational, please make note in remarks.
High Tech Radiology	For all High-Tech Radiology requests, submit auth request to Mass General Brigham Health Plan

Requested Service	Comments
Infertility	Includes assisted reproductive services
Non-Emergent Transportation	Non-emergent Medically Necessary Transportation
Observation	Observation (OBV) that becomes an inpatient admission, a separate authorization must be submitted. The provider must alsoindicate in the Remarks that the OBV has converted to an Inpatient Admission and include the OBV PA number.
Occupational/Physical Therapy	**My Care Family (MVACO) members –** PA Required **Commercial members beyond the benefit limit** – Requests are considered individual considerations. Note this request in the remarks section. **Evaluation**: Add 1 visit to total visits requested and note in Remarks "1 Visit"
Oral Surgery	
Orthotics/Prosthetic Device	
Other Medical	When a specific drop-down service does not apply, please use this and specify request within the remarks.
Outpatient Infusion	• Code Checker is not valid for this service • In the remarks section, indicate the vendor that approved the medication.
Pain Management	Office visits require a Referral and treatment requires a separate prior Authorization.
Specialty Medication*	• For those Specialty Medications that require PA review by Mass General Brigham Health Plan, please refer to Prior Authorization Guidelines on the Mass General Brigham Health Plan Provider Site. • Specialty Medications requiring review by Novologix will be noted on the code checker.
Speech Therapy	• **My Care Family (MVACO) members –** PA Required • **Commercial members beyond the benefit limit** – Requests areconsidered individual considerations. Note this request in the remarks section.

Requested Service	Comments
	Evaluation: Add 1 visit to total visits requested and note in Remarks "1 Visit"
Surgical Day Care	• Use for SDC (Surgical Day Care) • Please note, a referral to the specialist is also required before you submit a request for the surgery. • For a list of Surgical Procedures that require PA, please refer to Prior Authorization Guidelines on the Mass General Brigham Health Plan's Provider Site. • SDC: If a patient remains in observation beyond eight hours, an observation auth must be submitted. • If SDC becomes an admission, a separate authorization must be submitted. Provider must also indicate in the Remarks section that the SDC converted to inpatient stay and include the SDC PA number. If the date for the SDC changes but is within the 90-day date span of auth, no action is required by the provider.
Transplant	Auth request should be submitted for Evaluation and Management

6. **Servicing Facility/Provider**: Enter the name or NPI of the facility where the services are being rendered and click **Search**. Click **Select** next to the appropriate facility.
    a. **Servicing Surgeon**: Will only appear when requesting service type is equal to surgical. 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.
    b. **For DME requests**, the servicing provider must be the DME vendor.

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 code and click search. Click select next to the appropriate procedure. (Refer to the table below for specific coding requirements).

10. **Units/Visits**: this field will appear after a procedure code has been selected.
    a. For OT/PT Evaluation: Add 1 visit to total visits request and note in remarks "1 visit for Evaluation."

Outpatient Service Type	Code Requirements
Acupuncture	CPT/ HCPCS Code
Cardiac/Cardiac Imaging	CPT/ HCPCS Code
Chiropractic	CPT/ HCPCS Code
Dental Accident	CPT Code
DME Enteral Product*	HCPCS codes (add modifiers in remarks section)
DME Purchase	HCPCS codes (add modifiers in remarks section)
DME Rental	HCPCS codes (add modifiers in remarks section)
EIBI (formerly EI ABA/EI ABT*)	CPT/ HCPCS Code
Experimental and/or Investigational*	CPT/ HCPCS Code
High Tech Radiology	CPT/ HCPCS Code
Infertility/In-Vitro Fertilization	CPT/ HCPCS Code
Non-Emergent Transportation	CPT/ HCPCS Code
Observation	Rev code – OBV use 0762; OB OBV use 0729
Occupational/Physical Therapy (My Care Family [MVACO] members ONLY)	CPT Code (Only 1 code is required) Example: 97110
Oral Surgery	CPT/ HCPCS Code
Orthotic/Prosthetic Device	HCPCS codes (Orthotics L0112 – L4631 and Prosthetics L5000 – L8699)
Other Medical	Submit appropriate procedure code.
Outpatient Infusion	CPT/ HCPCS Code
Pain Management	CPT/ HCPCS Code
Specialty Medication*	CPT/ HCPCS Code
Speech Therapy (My Care Family [MVACO] members ONLY)	CPT Code (Only 1 code is required) Example: 92507
Surgical (Use for SDC)	CPT Code **Note**: For a list of Surgical Procedures that require PA, please refer to Prior Authorization Guidelines on the Mass General Brigham Health Plan's Provider Site.

Outpatient Service Type	Code Requirements
Transplant	Use Evaluation & Management CPT Codes (99201 – 99215)

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

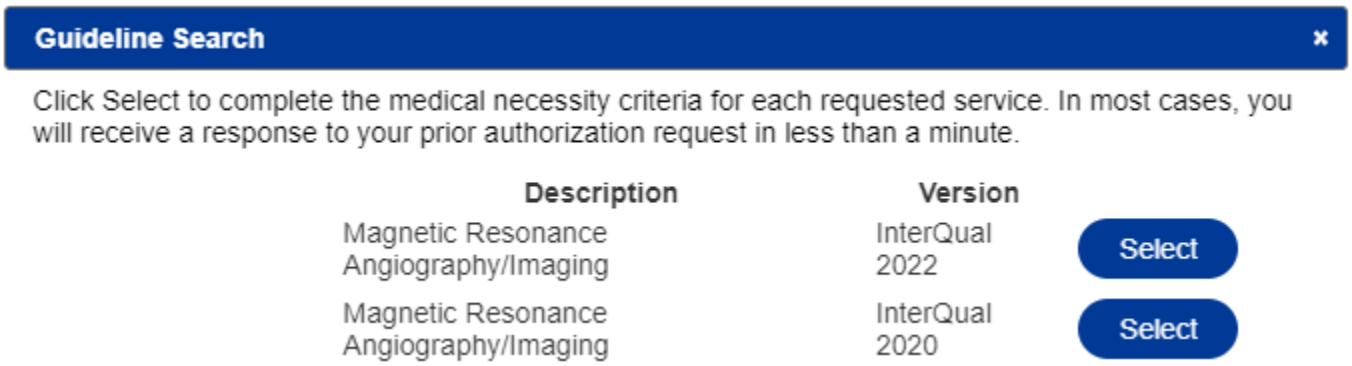
12. **Remarks**: Use for brief clinical information, individual consideration requests, or other information (see below). There is a 255-character limit. If you are attaching or faxing clinical, in Provider.MassGeneralBrighamHealthPlan.org, please make a note in the remarks.

13. **Submit**.

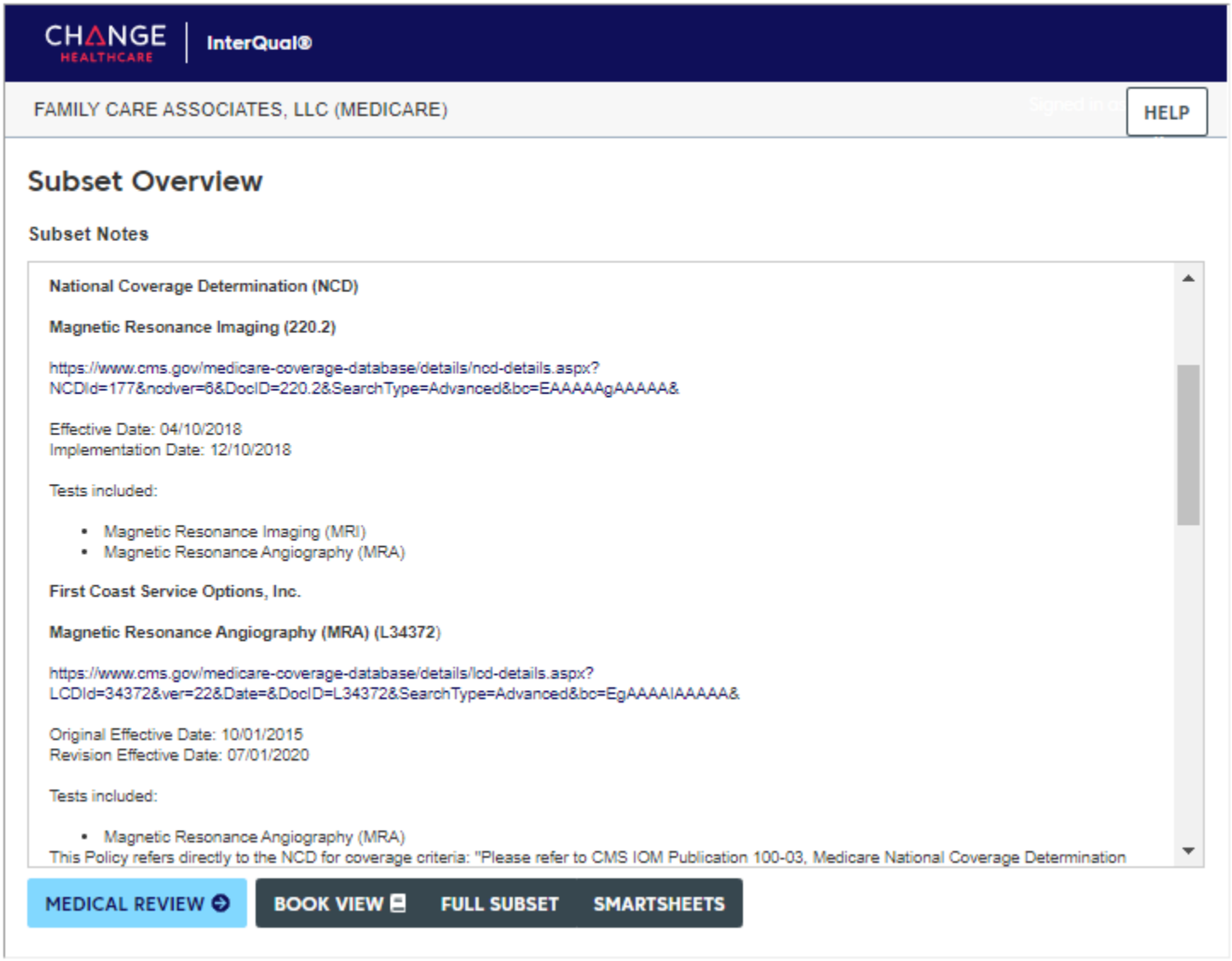
InterQual Connect

For each service requested, you will be prompted go through InterQual Connect for medical criteria review. If you have more than 1 service requested, each service will be reviewed one at a time (each IQC criteria will automatically appear, at the completion of each review, per the codes entered).

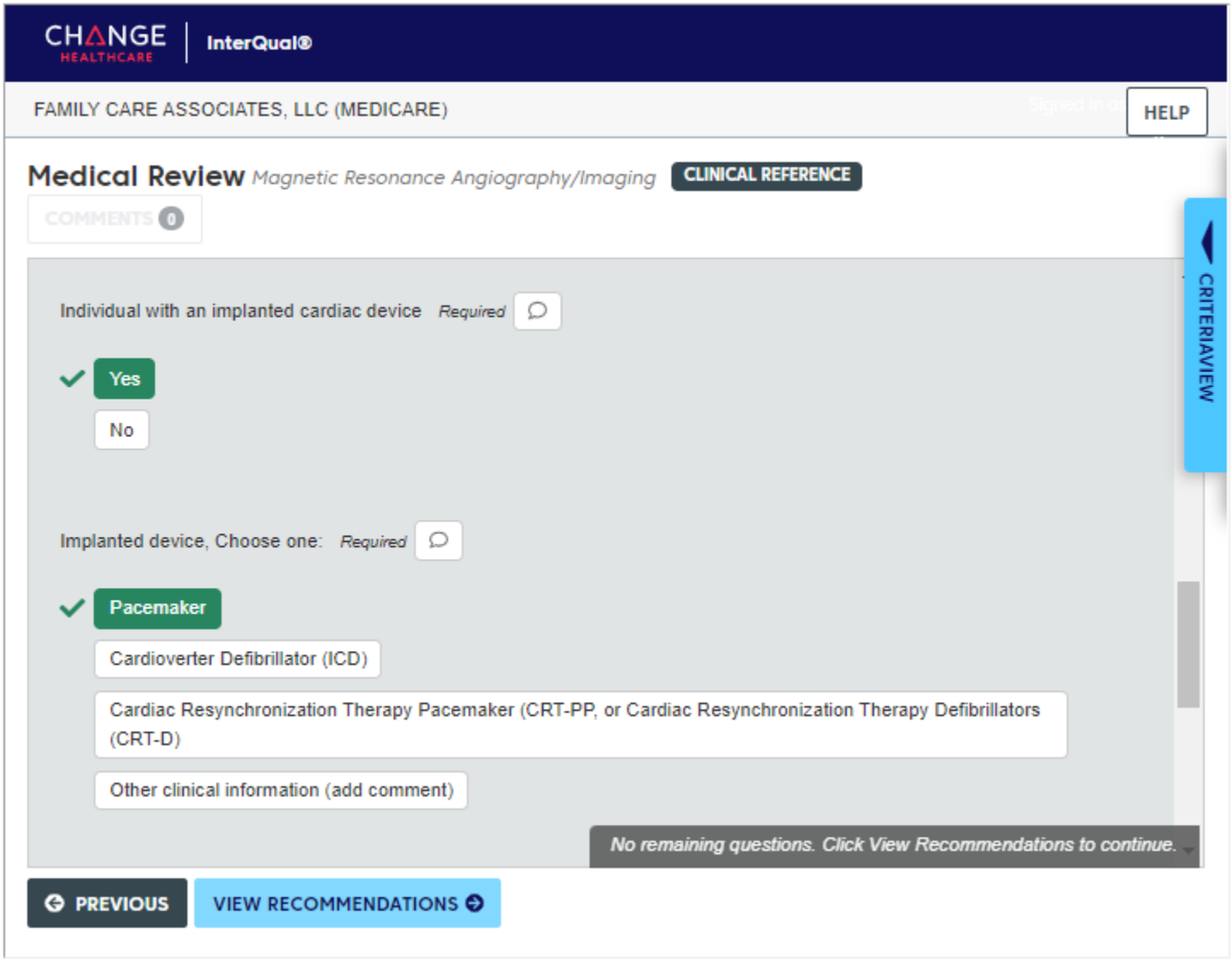
1. Based on the code you specify; a list of possible criteria subsets will appear. Select the appropriate subset for this request.



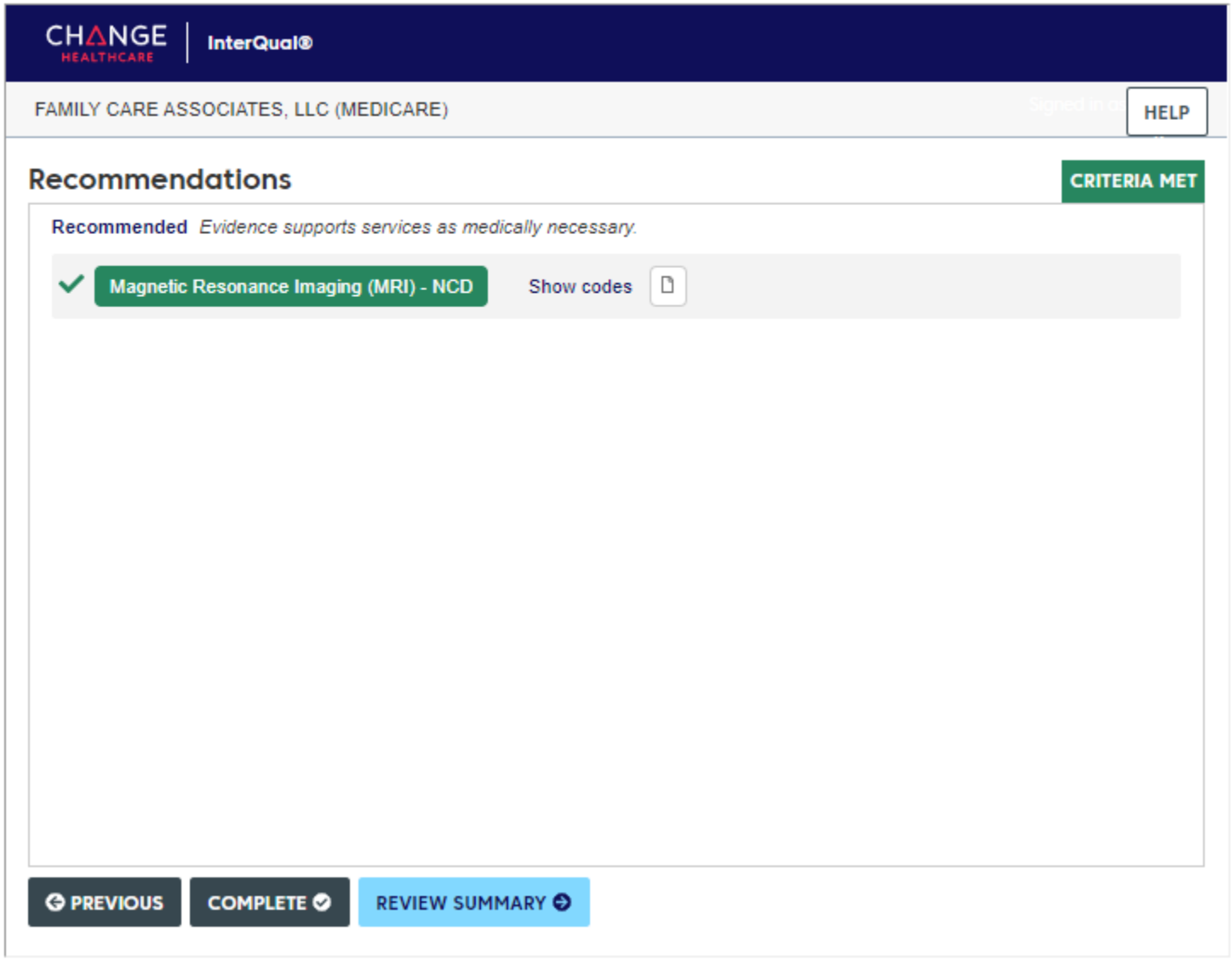
2. Review the subset overview and select **Medical Review** to proceed. You can also select different views of the criteria:
    - Book View: View the medical necessary criteria for the service in Q&A format
    - Full Subset: Enables you to see all the clinical scenarios supported by the criteria
    - Smartsheets: Access a PDF of a subset that identifies the medical documentation required to support preauthorization



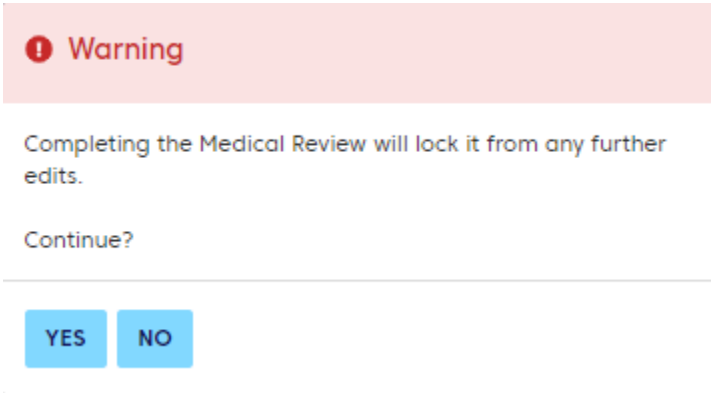
3. A series of question & answers will appear in yes/no or multiple-choice format. Select the answers that are applicable based on the patient's clinical information (medical record). The answers you provide will lead to evidence-based recommendations. Click on **View Recommendations** to proceed.



4. The clinical recommendations will appear. Click on **Review Summary** to access a printable summary page of the Q&A and recommendations. Click on **Complete** to finalize the InterQual medical review.



5. When you select **Complete**, the following message will appear to confirm that no further edits can be made after this point. Select **Yes** to confirm. If you requested additional services for medical review, you will be taken back to step 1 to complete the review for those services.



6. Once you complete the medical review and obtain recommendations for all services that you requested, you will be taken back to the authorization request form. At the bottom of the form, you will see the clinical recommendations for each service requested. Press **Submit** to complete your request.

   Important: your authorization is not submitted to Mass General Brigham Health Plan until you complete this step.

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

Authorizations/Referral Information

Authorization/Referral ID:	22348R00000	Member:	LHASO, JOHN
Member ID:	1007010070	Member Date Of Birth:	01/01/1954
Product:	MEDICARE ADVANTAGE	Member PCP:	
Referred By:	FAMILY CARE ASSOCIATES, LLC (1417969817)	Referred To:	BRIGHAM AND WOMEN'S HOSPITAL (1790717650)
Inpatient/Outpatient:	Inpatient	Pay To:	BRIGHAM AND WOMEN'S HOSPITAL (1790717650)
Diagnosis Code:	N50.82	Diagnosis Description:	Scrotal pain
Authorization/Referral Status:	**PENDING** A -General Medicine	Authorization/Referral Date:	12/14/2022
Service Start Date:	12/14/2022	Service End Date:	12/19/2022

Authorization/Referral Service Lines

Line	Status	Code	Code Type	Modifier	Description	Total Units	Used Units
1	PENDING				Inpatient Stay	5	0

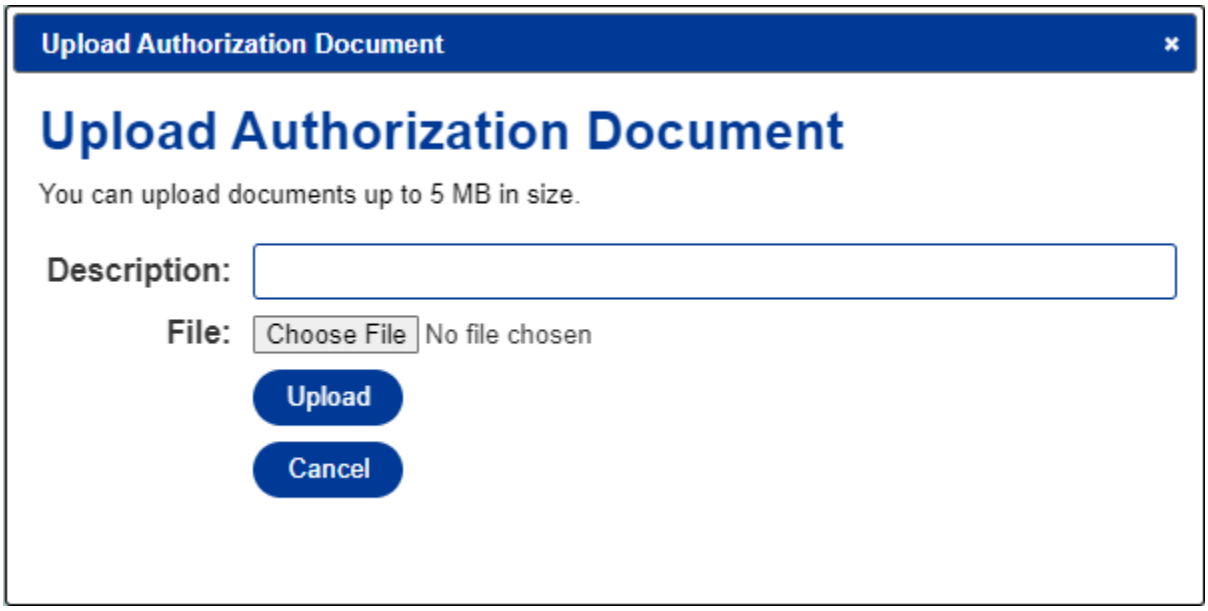
Authorization/Referral Supporting Documentation

Description	Document	Size	Uploaded	
Clinicals	UserGuideInpatient_2.7.2022.pdf	896KB	12/14/2022 11:40:AM	Download

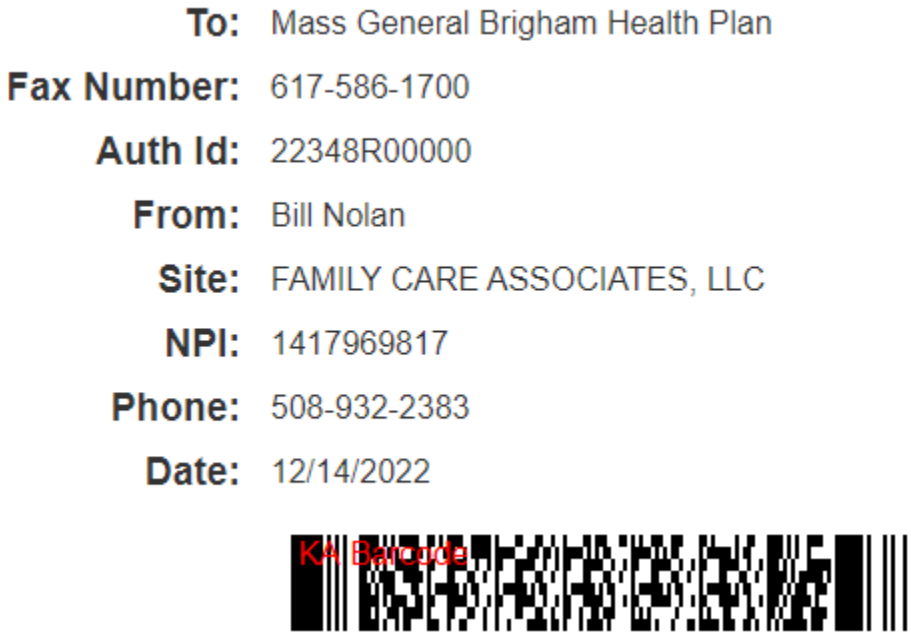
Submit Document Fax Document

- 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

Revise Request

Authorizations/Referral Information

Authorization/Referral ID:	22348R00000	Member:	LHASO, JOHN
Member ID:	1007010070	Member Date Of Birth:	01/01/1954
Product:	MEDICARE ADVANTAGE	Member PCP:	
Referred By:	FAMILY CARE ASSOCIATES, LLC (1417969817)	Referred To:	BRIGHAM AND WOMEN'S HOSPITAL (1790717650)
Inpatient/Outpatient:	Inpatient	Pay To:	BRIGHAM AND WOMEN'S HOSPITAL (1790717650)
Diagnosis Code:	N50.82	Diagnosis Description:	Scrotal pain
Authorization/Referral Status:	**APPROVED** A -General Medicine	Authorization/Referral Date:	12/14/2022
Service Start Date:	12/14/2022	Service End Date:	12/19/2022

Authorization/Referral Service Lines

Line	Status	Code	Code Type	Modifier	Description	Total Units	Used Units
1	APPROVED				Inpatient Stay	5	0

Authorization/Referral Supporting Documentation

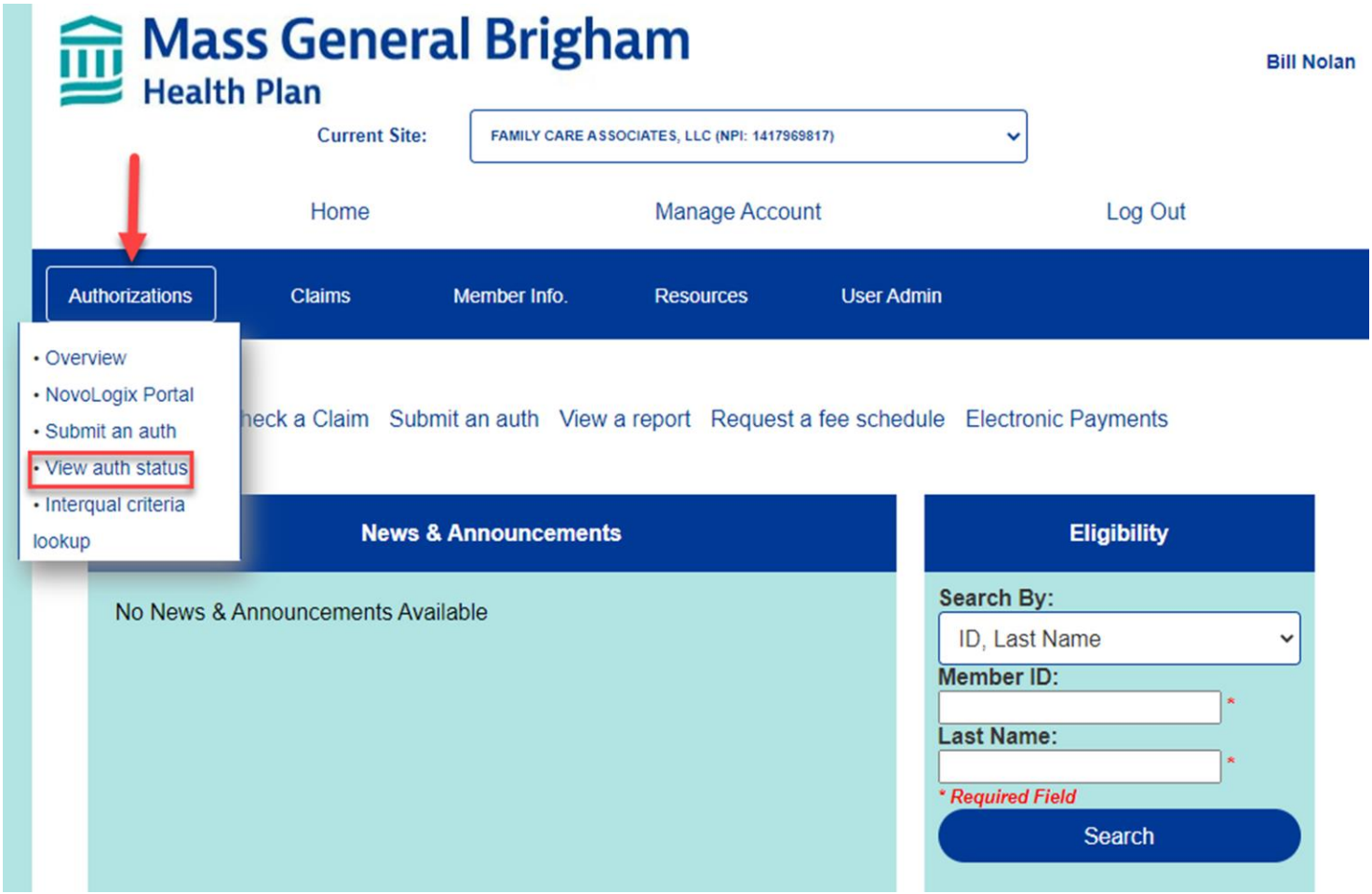
Description	Document	Size	Uploaded	
Clinicals	UserGuideInpatient_2.7.2022.pdf	896KB	12/14/2022 11:40:AM	Download

Submit Document Fax Document

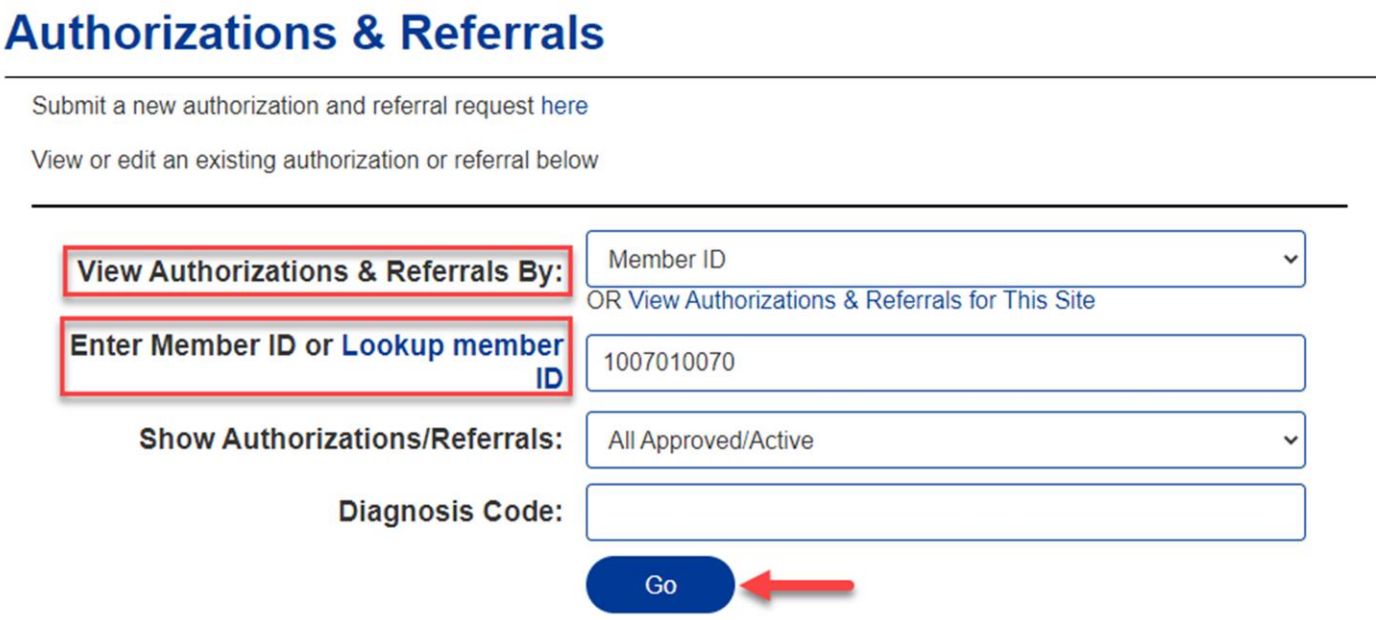
Revisions

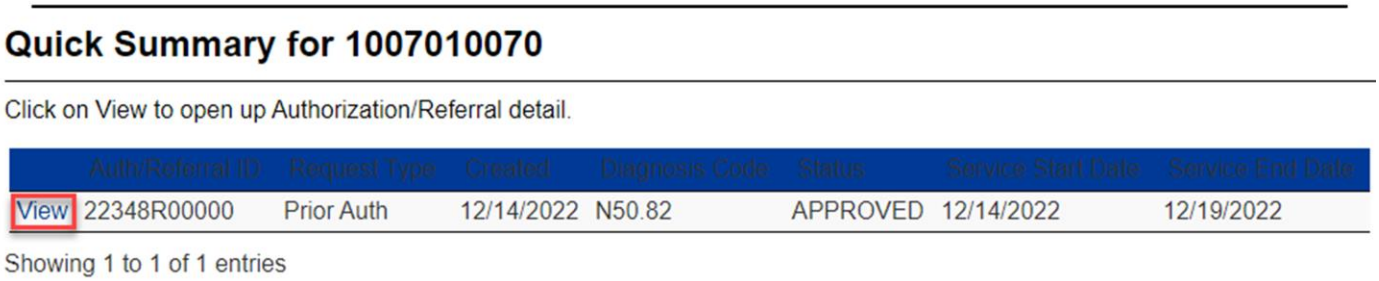
Edit an Existing Service Request (Use for Concurrent Review)

- A Service 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**.

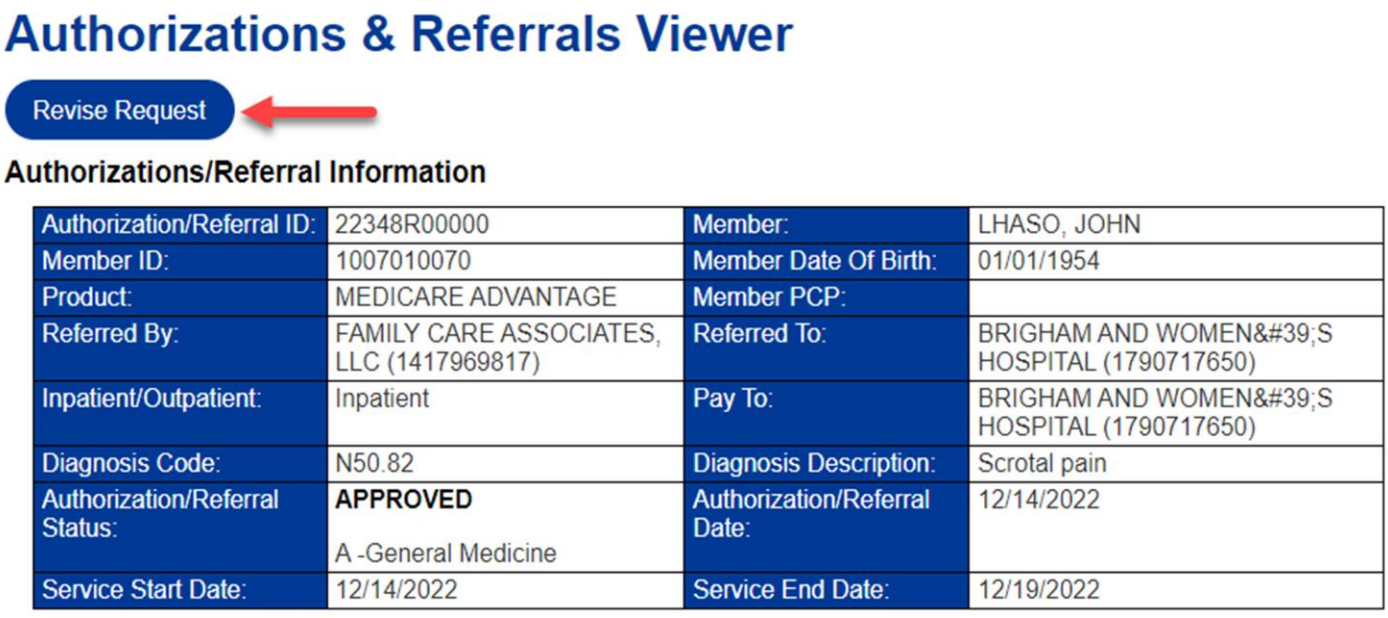


- Under **View Authorizations & Referrals By**, use the **Member ID** or **Authorization/Referral ID** and click **Go**.
  - If **Member ID** is selected, choose the specific authorization number you want to revise and click **View**.
  - If **Authorization/Referral ID** is selected, it will automatically bring you to the authorization.

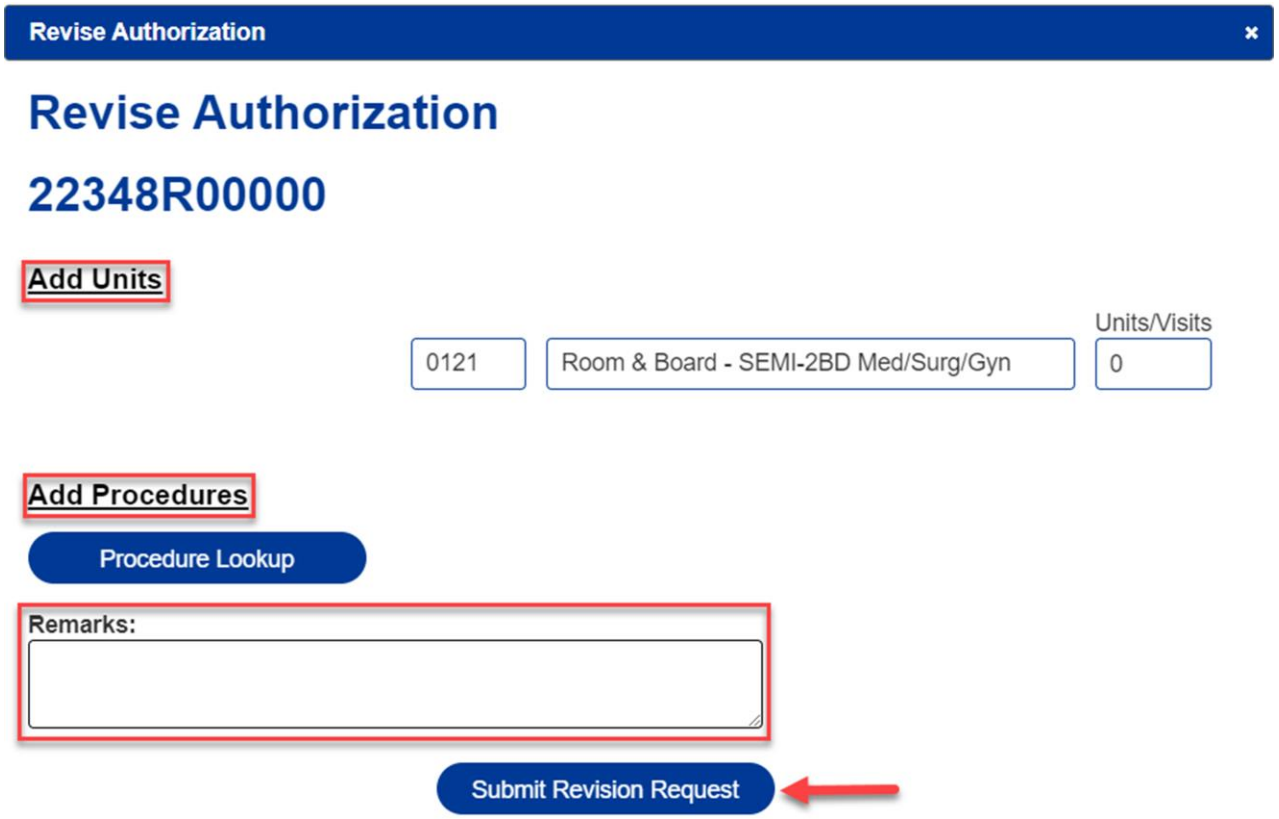




- Click on **Revise Request**. If the **Revise Authorization** screen does not appear, user should **press CTRL + F5** to refresh the browser.



- Enter additional requested units, add a procedure, and/or enter remarks. Click on **Submit Revision Request**.



Authorization Revision (Concurrent Review) Rules

- **Incorrect Service Request Type Submitted**: If incorrect Service Type was requested (example: Rehabilitation vs Skilled Nursing Facility), user will need to enter a new authorization and enter the following in the remarks section:
  - "Incorrect Service type in authorization # _. Please close this auth."
  - Mass General Brigham Health Plan will close the incorrect authorization and process new request.

- **Requesting a date extension**: enter the date in the remarks section.

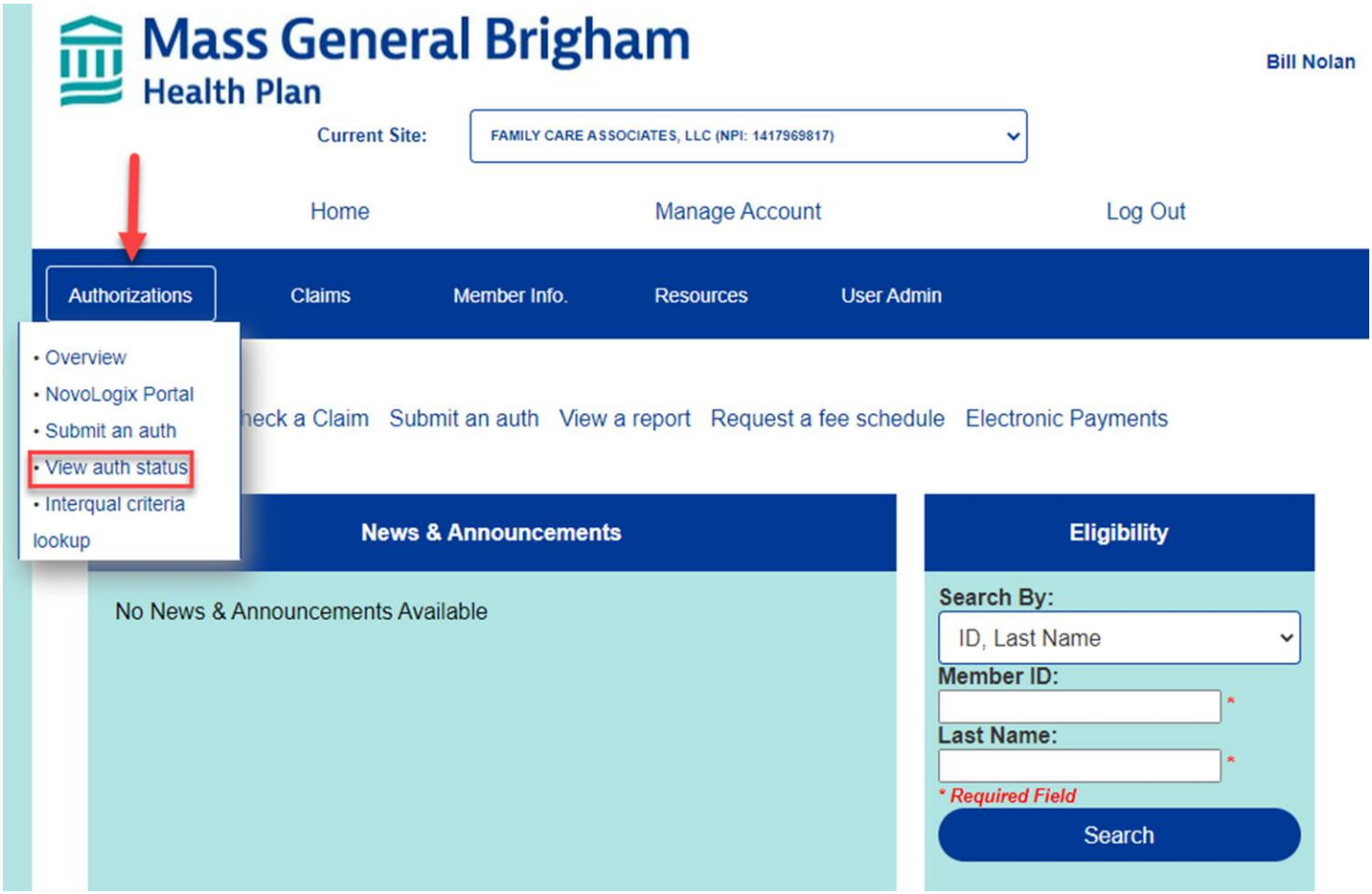
- **Requesting a date change**: enter the date in the remarks section.

- **Requesting additional procedures**: Click on procedure lookup, choose procedure, and add requested units.
  - Mass General Brigham Health Plan will not accept corrected procedure codes through Provider.MassGeneralBrighamHealthPlan.org. Please submit a revision and put the corrected code in the remarks.

- **Remarks**: Use for status change, clinical information, corrected procedure code, corrected dates, date extensions, when observation or surgical day care auths convert to inpatient admissions, experimental and investigational requests etc.

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