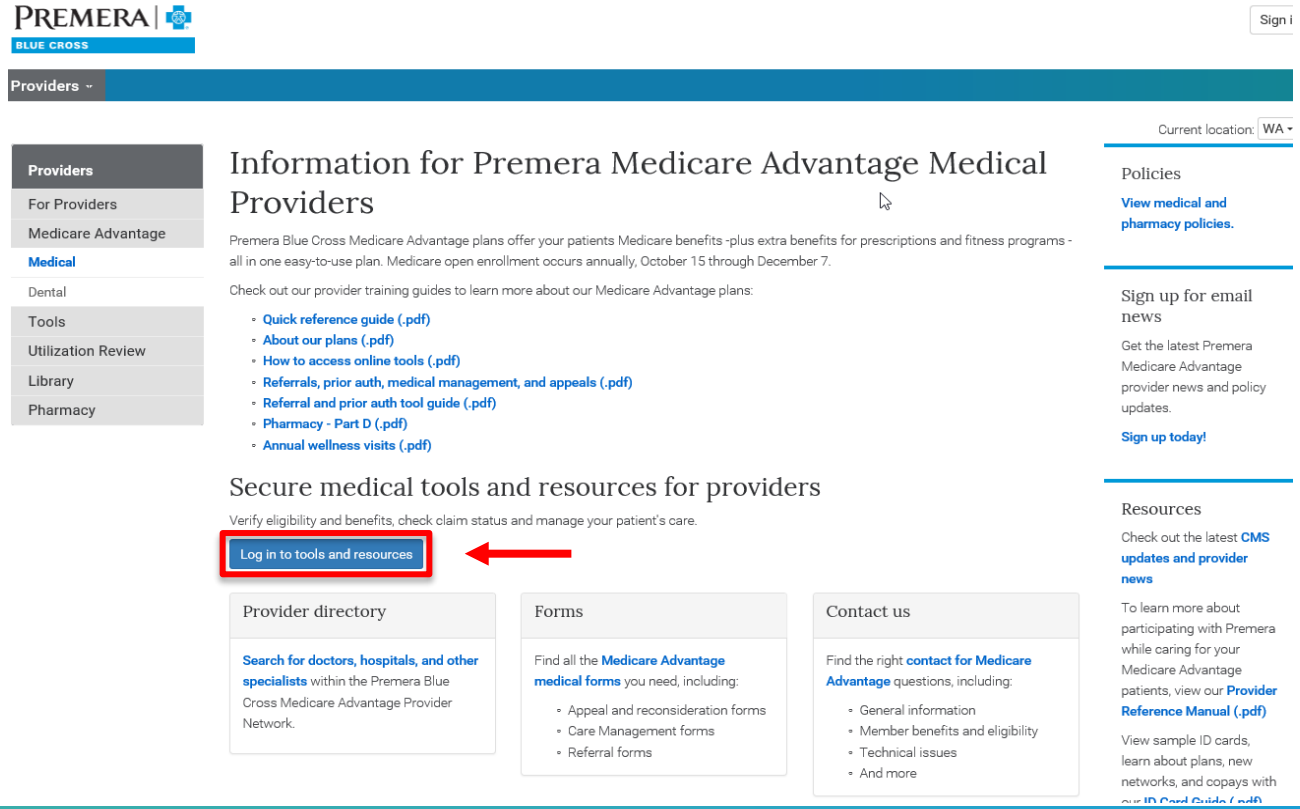
Referral and Prior Authorization Tool Guide

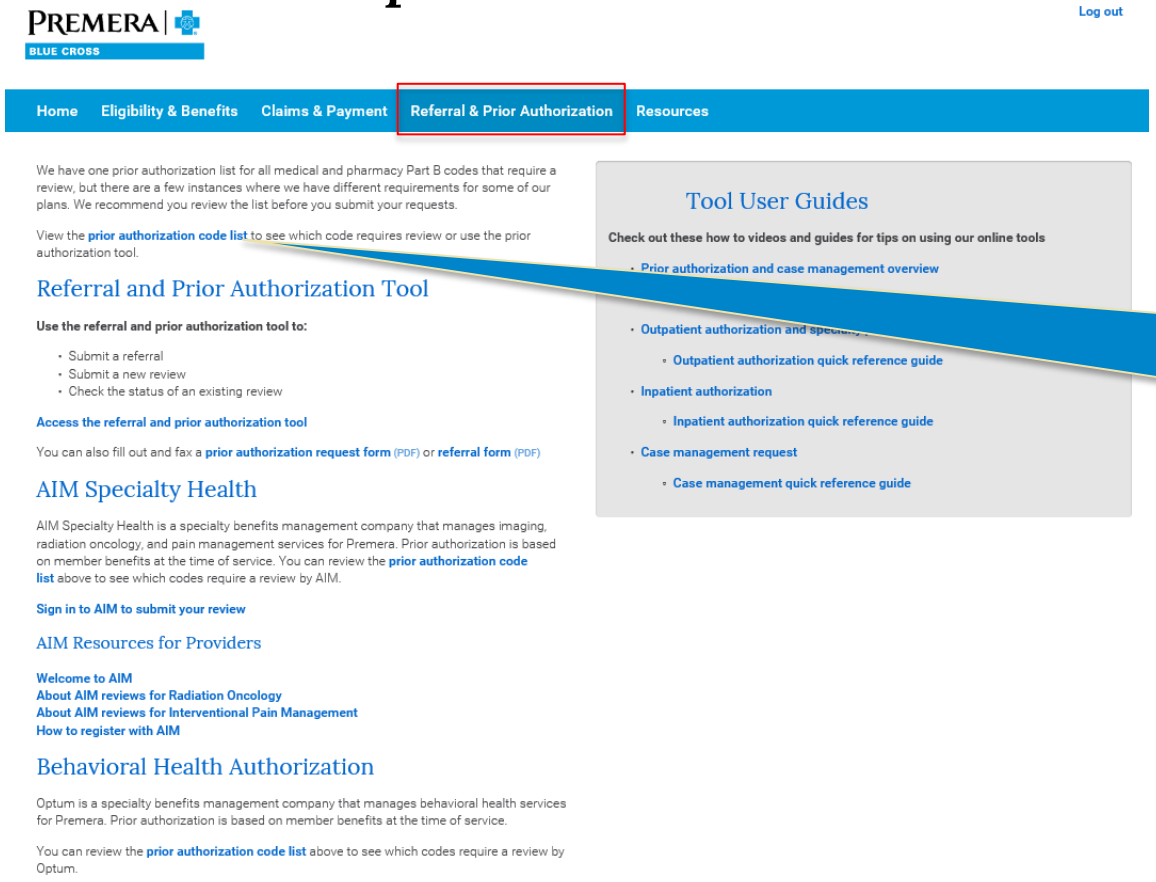
044509 (01-30-2022)

Medicare Advantage landing page

premera.com/wa/provider/medicare-advantage/

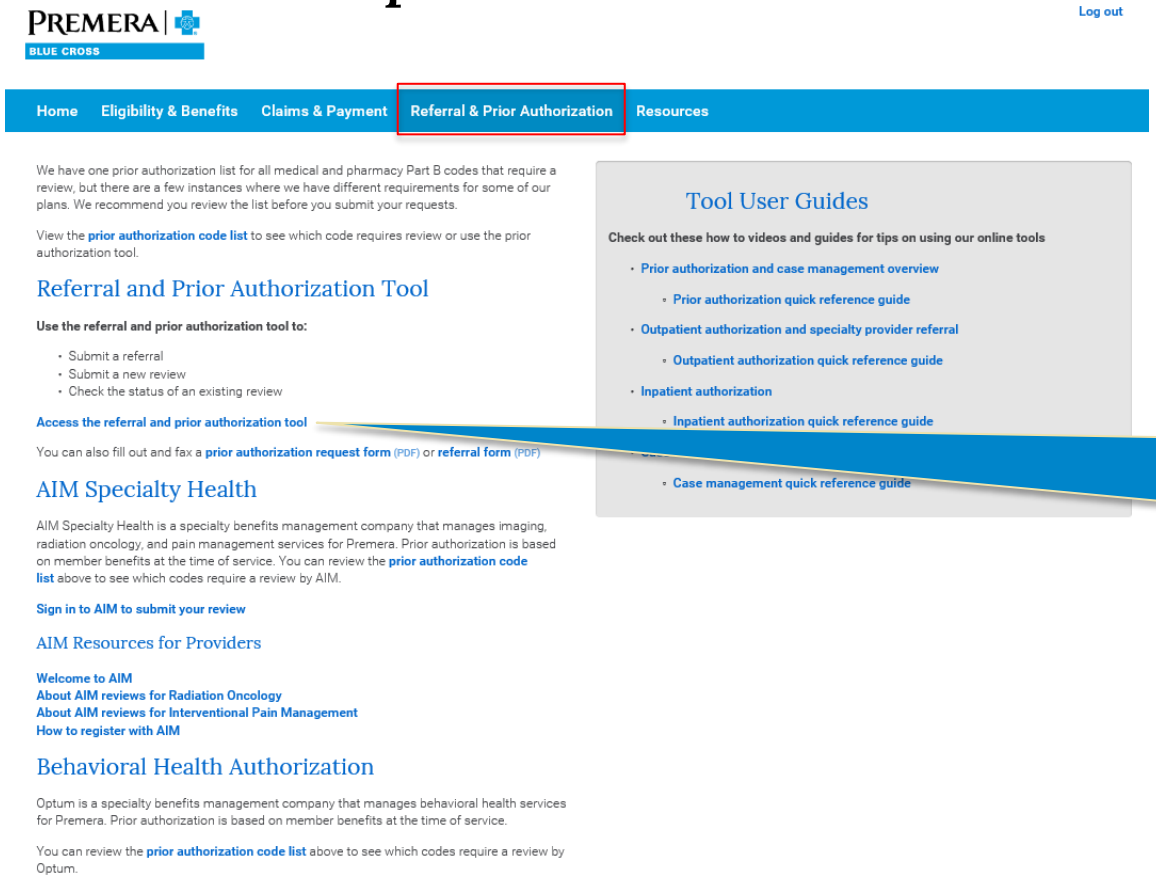


Referral & prior authorization: Code check



Please check the prior authorization code list prior to submission to ensure your service requires prior authorization.

Referral & prior authorization tool

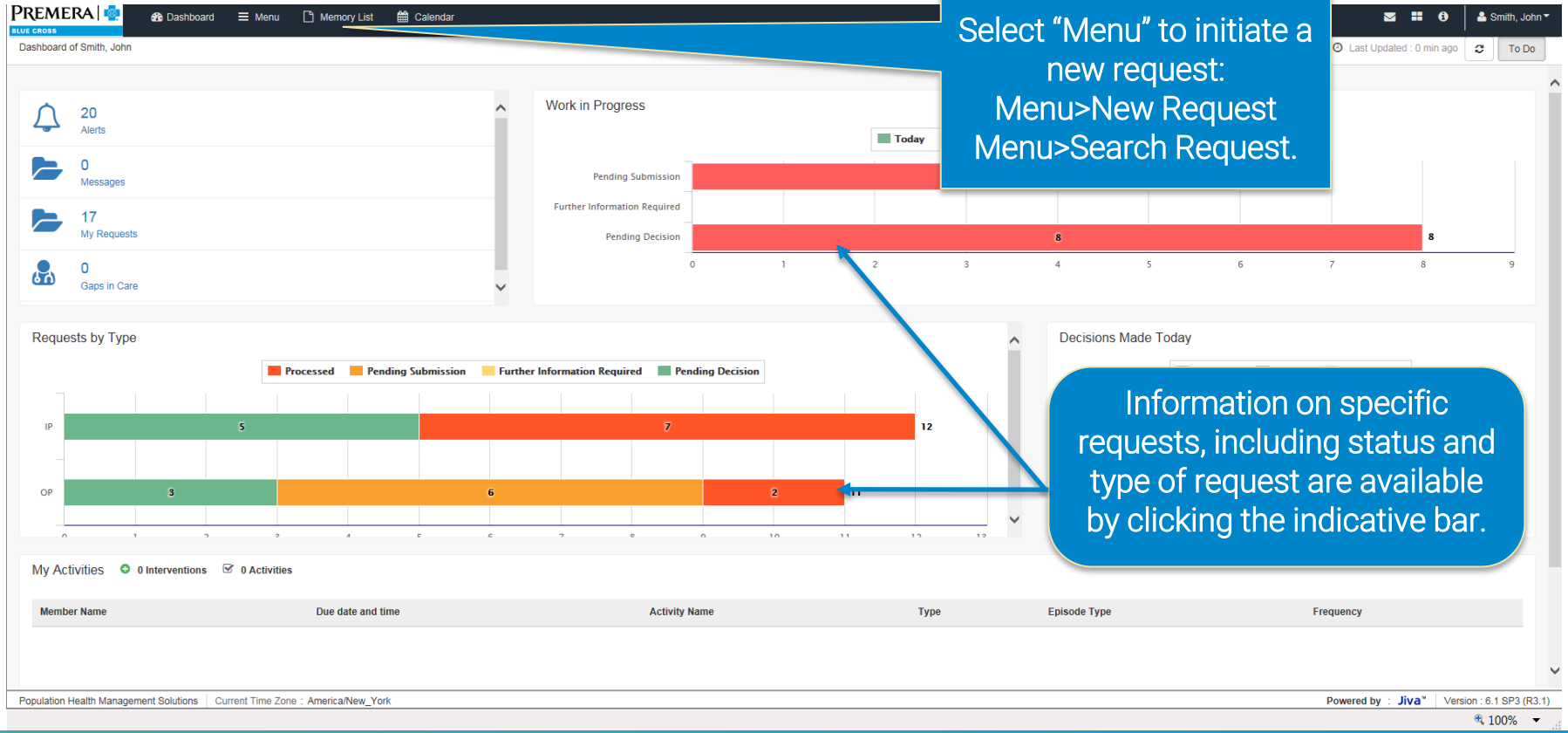


Access the Referral and Prior authorization tool: Jiva.

Referral & prior authorization tool: Jiva

- Jiva website is accessed via single sign on (SSO) from the provider website.
- Jiva is the comprehensive care management tool used by providers and health management staff.
- Use Jiva for:
  - Entering referrals for specialists
  - Inpatient (IP) and outpatient (OP) prior authorization requests
  - Checking the status of requests

Referral & prior authorization tool: Jiva – Dashboard



Select "Menu" to initiate a new request:
Menu>New Request
Menu>Search Request.

Information on specific requests, including status and type of request are available by clicking the indicative bar.

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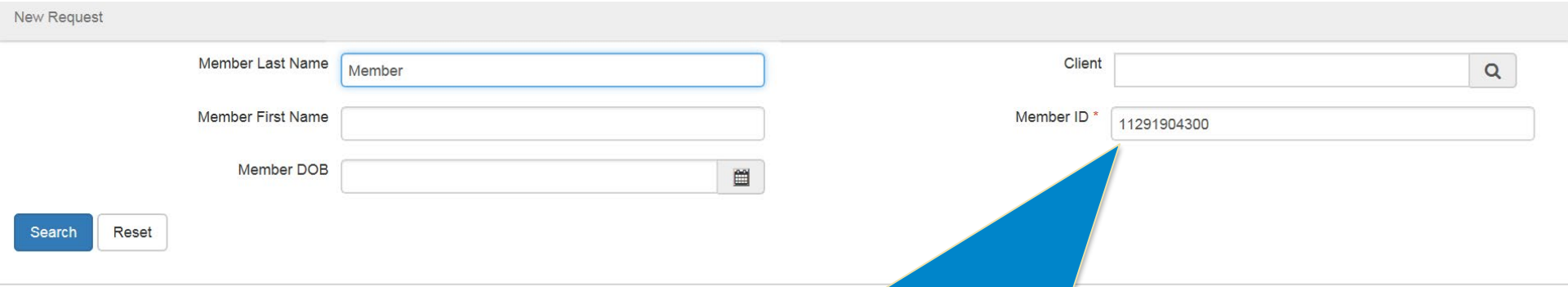
Jiva: Dashboard functions

- Once a request has been created in Jiva, it's defined as an episode.
- Widgets are actionable boxes that help providers access alerts and requests.
- From the dashboard, a provider views status of the episodes, including:
  - Approval
  - Denial
  - Needs more information status
  - Documented member contact
- Episodes are viewed by type, including:
  - Inpatient
  - Outpatient (OP)
- Use the indicative bars on the dashboard for complete request or status details.

Jiva: How to search for a member



Navigate to “Menu” and “New Request”
Under new request, Member ID is a mandatory field.
Please note: ALPHA pre-fix should be removed from Member ID and two trailing 00’s added to end to retrieve member information.

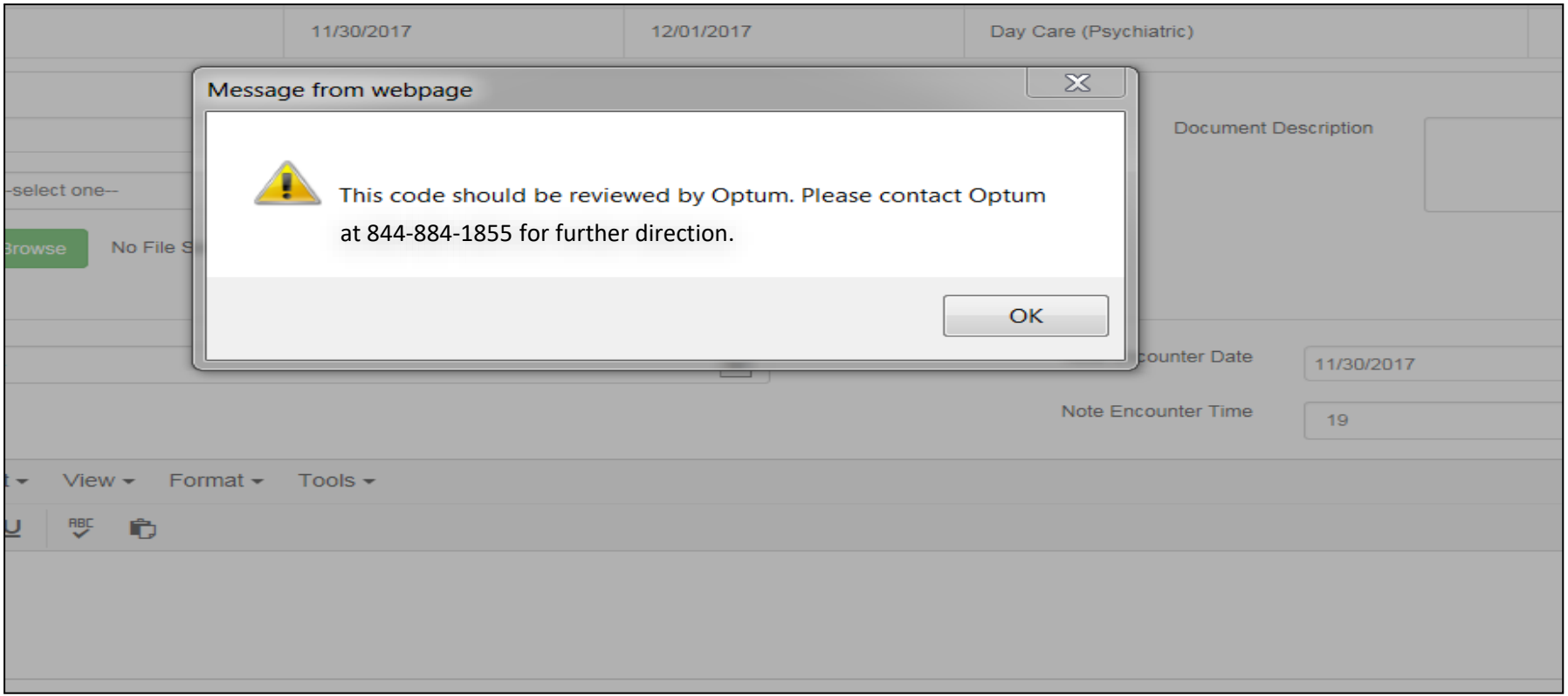
Adding new requests

New requests are made by navigating to:

- Menu> Provider> New Request
- Menu> My Members> click on member's name to enter desired member's chart > + Add Request
- Menu> Search Request> Add New Request

Please Note: For requests processed by delegated entities or a vendor, providers will receive a hard-stop alert and be instructed to contact delegated entity or the vendor with any further questions.

Hard-stop alert: Behavioral health



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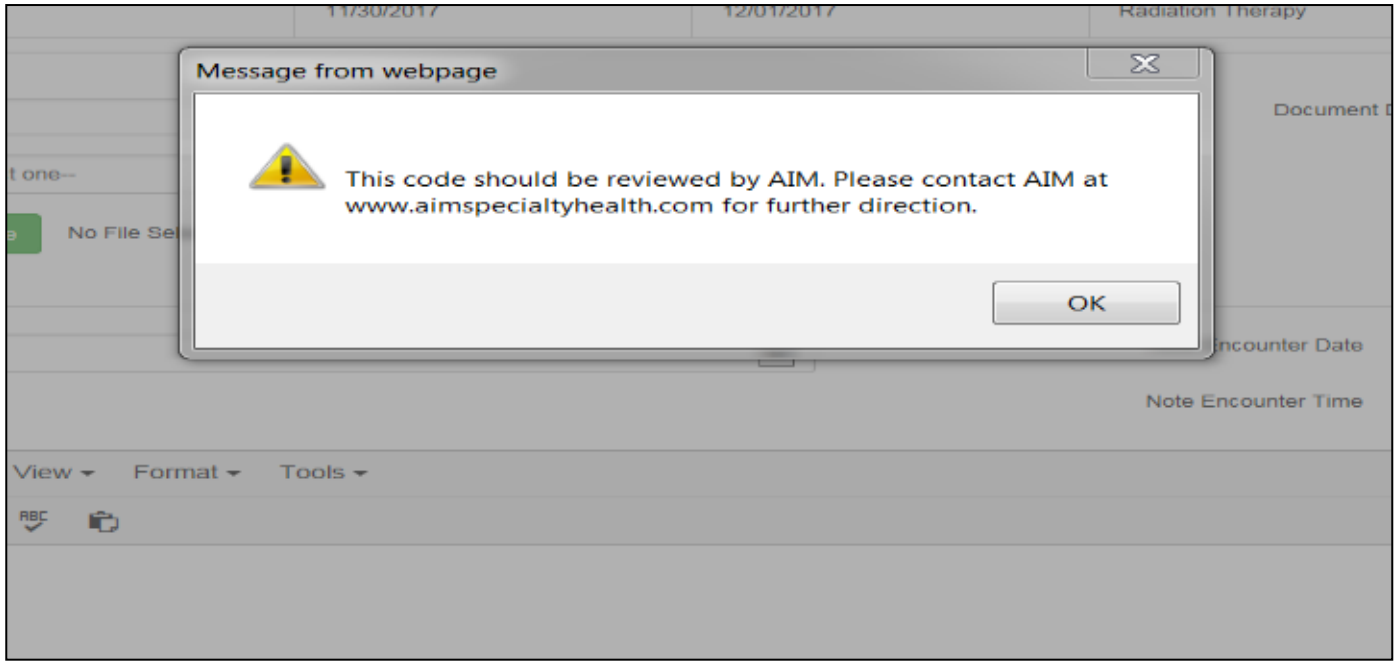
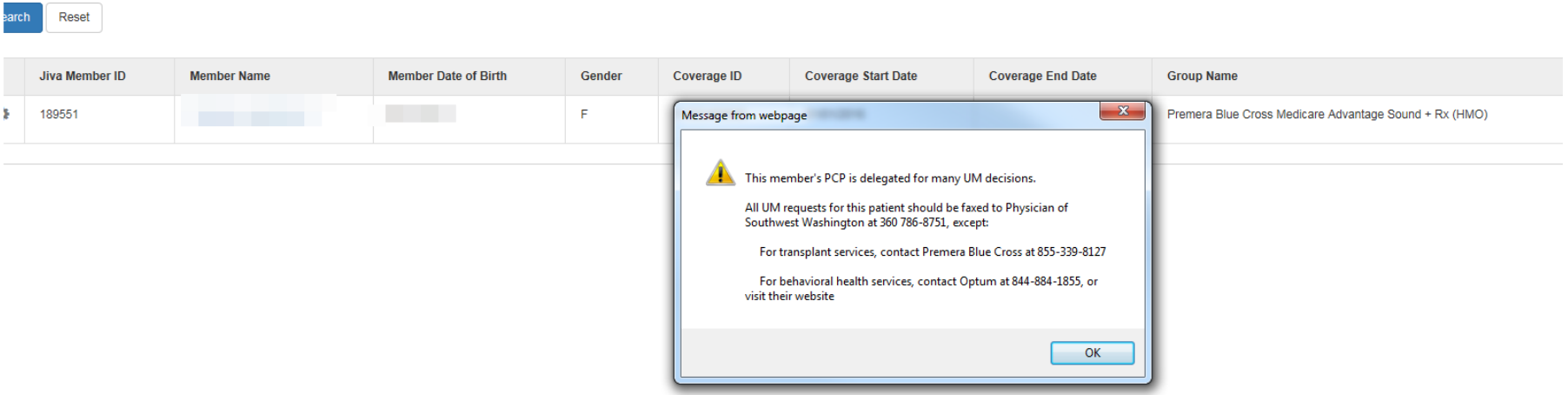
Hard-stop alert: High-tech radiology, interventional pain management, radiation therapy and cardiac imaging authorizations



Hard-stop alert: Delegated Providers



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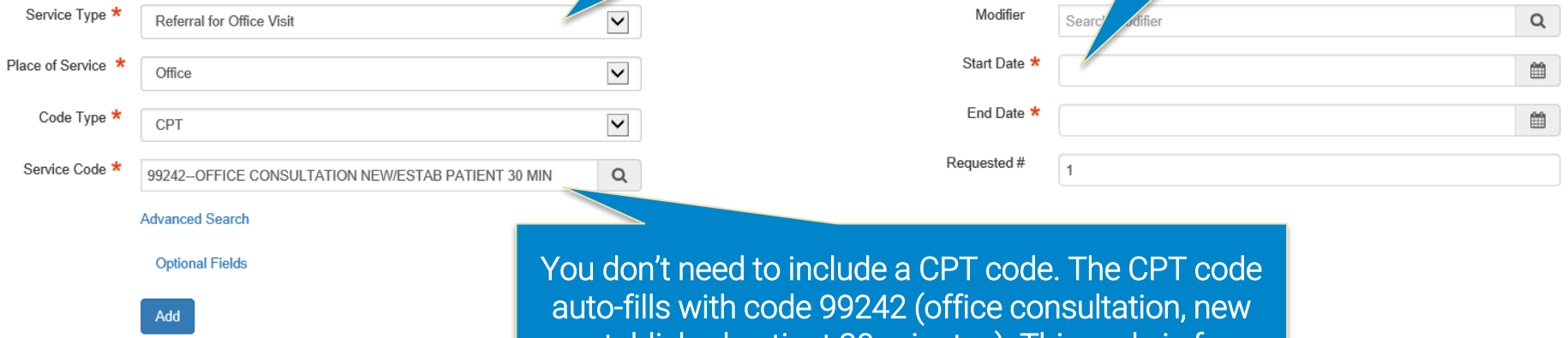
Referrals for specialty care

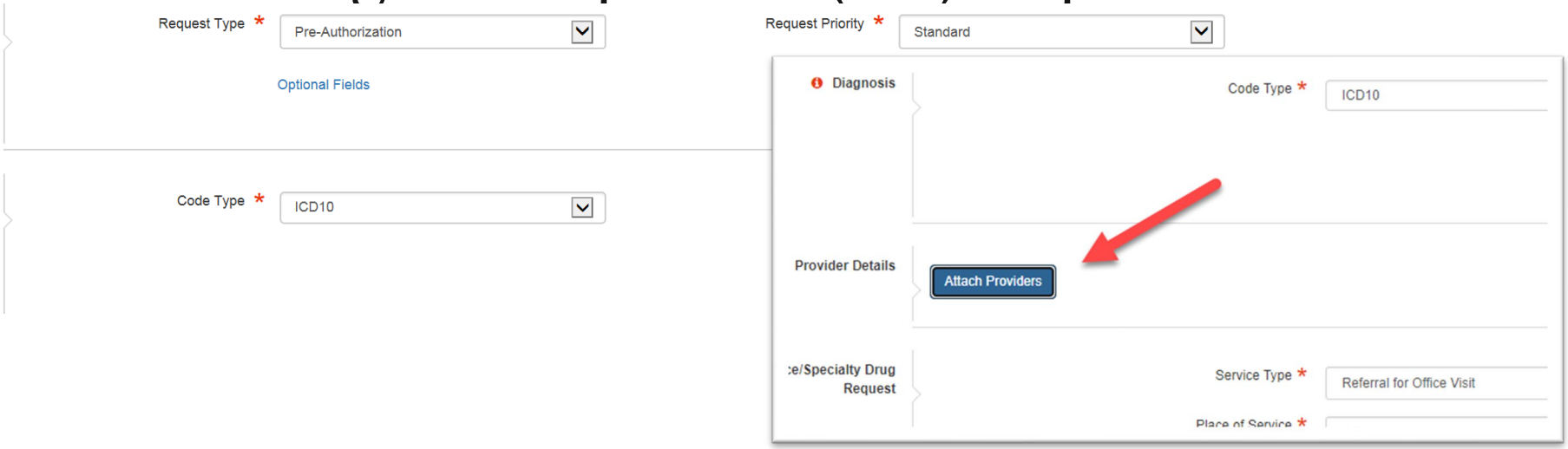
Select Place of Service ='Referral for Office Visit'.

Enter the requested # of visits, start date and end date.



You don't need to include a CPT code. The CPT code auto-fills with code 99242 (office consultation, new established patient 30-minutes). This code is for internal processes only; it doesn't need to match the CPT code on the specialist's claim.

Submitting an outpatient (OP) request & referral



- OP episodes need to have both a **requesting provider and treating provider** attached.
- If an OP request contains CPT codes or HCPCS codes that are not on the prior authorization list, you do not need to submit a request unless you are requesting an organization determination.
- Request will auto-approve if the group has seamless access and refers within their partner system.
- All providers can submit these requests.

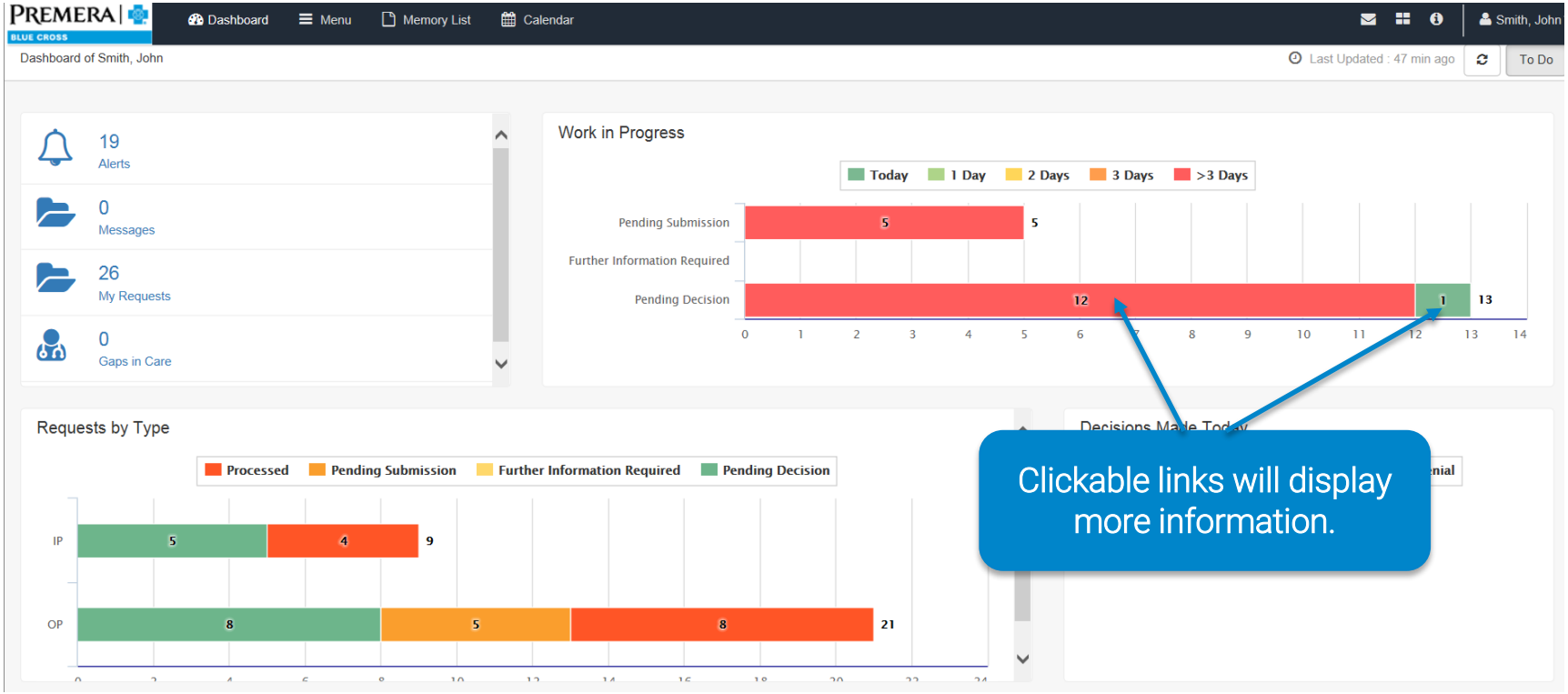
Prior authorizations

- An authorization pends for “Clinical Review Required” if the stay or service codes exist on the Premera prior auth list.
- The request is received by the utilization management team and is reviewed using CMS criteria, medical policy, or InterQual™ Clinical Criteria.
- Providers see a decision based on the designated turnaround time for expedited (up to 72 hours), standard (up to 14 days), or retrospective requests (14 days). *Generally; although some exceptions may exist.
- For all types of requests, medical records can be attached.
- Necessary fields are indicated with an asterisk.*

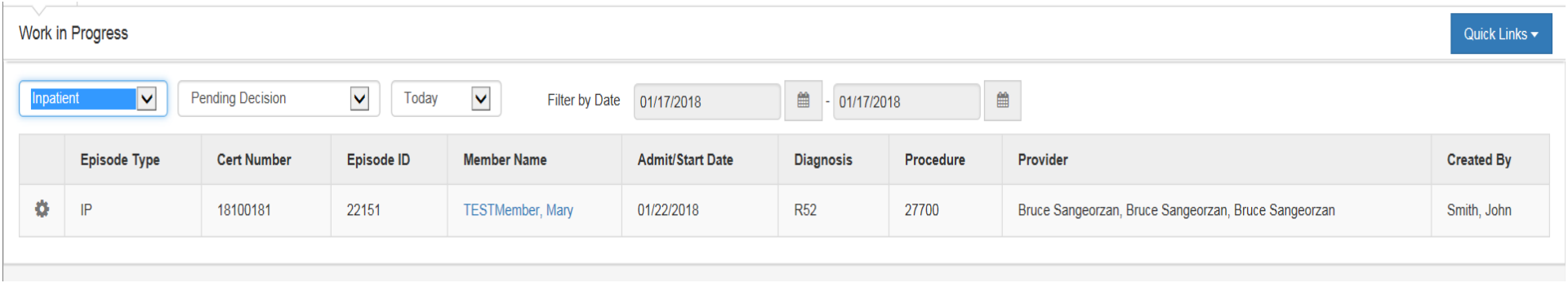
Submitting an inpatient (IP) request

- An inpatient episode can include many service requests, but only one initial stay request.
- IP episodes need to have an **admitting, requesting, treating provider, and servicing facility attached.**
- For inpatient hospital setting, please be sure to add CPT code 99222 to authorization request.
- If an IP request includes auto-approvable ICD-10 codes and/or CPT codes and includes in-network providers with an appropriate length of service, it may auto-approve.
- Otherwise, the episode pends for clinical review.

Checking status of requests



Checking status of requests: continued



- Requests made by providers are filtered by type (IP or OP) and status- pending submission, pending decision, further information required, or processed.
- Navigate back to the MCV (member centric view) by clicking on the member's name.

Additional user guides

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Log out

Home | Eligibility & Benefits | Claims & Payment | Referral & Prior Authorization | Resources

All Premera Medicare Advantage plans use the same prior authorization list for medical and pharmacy Part B codes. We recommend you review the list before you submit your requests. Have a question? **Contact Us**.

View the **prior authorization code list** to see which code requires review or use the prior authorization tool.

Referral and Prior Authorization Tool

Use the referral and prior authorization tool to:

- Submit a referral
- Submit a new review
- Check the status of an existing review

Access the referral and prior authorization tool

You can also fill out and fax a **prior authorization form or referral form**.

Please note: Per CMS, expedited requests should ONLY be requested when the health care provider believes that waiting for a decision under the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. Please be mindful of this definition when submitting your requests so that we can prioritize and process all requests appropriately.

Tool User Guides

Check out these guides for tips on using our online tools

- Prior Authorization Quick Reference Guide
- Outpatient Authorization and Specialty Provider Referrals Quick Reference Guide
- Inpatient Authorization Quick Reference Guide
- Case Management Quick Reference Guide