



# Avalon Precision Genetic Testing Management (PGTM)

# What We Will Cover

- Program Overview
- PGTM Policies
- Prior Authorization Process
- Diagnosis Exchange Registry
- Portal Capabilities
- Navigation of Prior Authorization System (PAS) for Providers
- Provider Support

# Program Overview

# What Are We Doing and Why

Beginning January 1, 2026, MVP is expanding its partnership with Avalon to provide laboratory benefit management services related to precision genetic testing management (PGTM).

*Avalon Healthcare Solutions is the world's first and only Lab Insights company, bringing together proven Lab Benefit Management solutions, lab science expertise, digitized lab values, and proprietary analytics to help health care insurers proactively inform appropriate care, reduce costs, and improve clinical outcomes.*



# PGTM Policies

# Policy Development

## Evidence-based Guidelines

- Dedicated full-time scientists support and maintain a robust library of routine and genetic outpatient laboratory policies
- All policies are researched, written, and maintained by dedicated science team, led by PhDs
- Demonstrated conditions of coverage
- Each policy has robust scientific rigor, typically using ~ 50 references



# PGTM Policies

MVP PGTM policies can be viewed by visiting **[mvphealthcare.com/policies](https://mvphealthcare.com/policies)** and selecting *MVP Precision Genetic Testing Management* policies.

- Policies are updated on a quarterly basis as newly presented evidence becomes available
- Provider will be notified 60-days in advance of enforcement and the policies will be available for viewing



# Prior Authorization Process

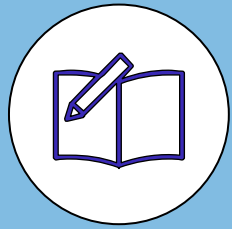


# Precision Genetic Testing Management

- Avalon's proprietary software **Prior Authorization System** (PAS) is used to review for medical necessity and ensure compliance to Client's laboratory policies
  - Utilization Management/Medical Necessity
- Medical necessity review is applied **pre and post service**
- **Preservice and Post Service review** applies to outpatient lab testing with the following exceptions:
  - Place of Service: ER, Inpatient, Observation
- **Preservice and Post Service review** determinations advice are provided in accordance with:
  - AMA CPT and HCPCS coding and ICD-10 diagnosis coding guidelines
  - Other laboratory and pathology coding guidelines
  - All applicable regulatory guidelines
  - Coverage criteria found in the client's policy

# Process of Intake, Medical Necessity Review, and Notification

Precision genetic testing management process



Provider/PSR Team  
Submits Request

## Intake

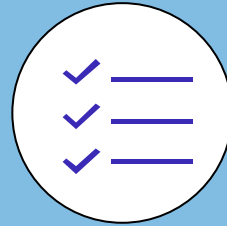
Provider submits request to Avalon. Intake verification for validity prior to clinical review.



Intake Coordinator  
Verifies Case Validity

## Medical Necessity Review

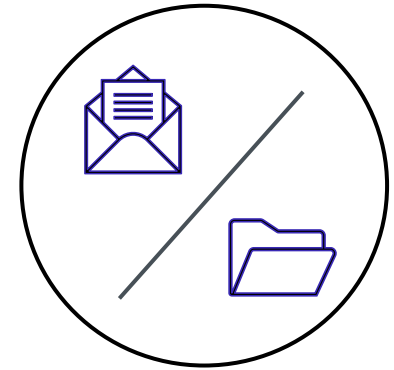
Avalon configures adopted policy and procedure codes into algorithms for possible automated approvals and/or cases will be routed for manual clinical review.



Nurse Reviews Coverage  
Criteria & Coding  
Parameters



Physician Reviews Coverage  
Criteria & Coding  
Parameters



Authorization Notification Sent  
to Member, Provider and MVP

## Provider/Member/HP Notification

Provider notification via fax and/or email.  
Member notification via determination letter.  
Health plan notification via daily authorization file.

# Diagnosis Exchange Registry

# General Workflow

Policy enforcement via post service automation



## Lab

Registers test and completes technical assessment for evaluation



## Palmetto GBA

Assesses registration and assigns Z-Code in DEX



## DEX

Sends Z-Code updates to Lab and Optum *and subsequently Avalon*



## Lab

Submits claim with Z-Code *and recommended CPT per DEX*



## MVP

Integrates to send claims to PGTM program to provides standardized coverage and payment

# Portal Capabilities

Requesting Member Authorizations

# Submission Request

## **Provider Submission Channels:**

- Phone (will require clinical submission via fax)
- Fax
- Web (directly in PAS)

**Intake Coordinator (IC)** will either enter information provided via phone/fax request or will verify information submitted directly in PAS for accuracy.

- If case contains all required documentation, the IC will forward for clinical review.
- If cases do not contain all required documentation, the IC will reject and send correspondence to provider advising of missing information and new submission will be required.



# Member Eligibility & Provider Validation

## Collect Key Details

- Member ID, name, DOB, date of service, gender and phone number.
- **Eligibility Check** performed:
  - Confirms coverage and line of business (LOB).
  - If ineligible → process ends with a message to the requestor to contact the member's health plan.

## Gather ordering and rendering provider details:

- Name, specialty, NPI, TIN, phone number, fax number, email (optional), and address.

## Provider Validation:

- Check against PAR (participating provider) file.
- Verify in-network (INN) status.
- Run sanction checks (via API to VerifyComply).
  - If sanctions exist → case is flagged, pended for review and the health plan is notified.

# Procedure Code Validation

Enter requested service details

- Procedure code(s) (up to 50)
- Z code(s) (up to 50)
- Descriptions auto populate for both
- Procedure Validation
  - PAS confirms codes are valid

## Service Information

### **Capture genetic counseling (GC) details (if required):**

- Counselor's name, credentials, and date of counseling.

### **Enter requested service details:**

- ICD-10 diagnosis codes (up to 12)
- CPT/HCPCS Units requested
  - If molecular pathology or unlisted codes have been requested, enter the test name in the box provided



# Clinical Information

Supporting the medical necessity of the request

## **Documents:**

- Can upload up to 25 files
- Must be PDF, Tiff or JPEG

## **Documentation Types**

- Lab Results
- Office/Clinic Notes including Physician's Order
- Pathology Reports
- Physician's Order
- Determination Letter



# Authorization Summary

Review Sections to Ensure Accuracy

- Member Information
- Provider Information
- Service Information
- Requested Procedure Code
- Clinical Information

## Attestation Statement:

- Confirms information submitted is valid and accurate
- Agrees to electronic notification

*Ready to **Submit** for Avalon Review*



# Determination Notification

## Outcomes:

- Fax and/or Email notifications sent to Ordering and Rendering Providers.

## Member and Provider Letters:

- **Approval** → Approval letter generated and mailed
- **Partial Approval** → Partial approval letter generated and mailed
- **Denial** → Denial letter generated and mailed



# Navigation of PAS for Providers

How to search for Member Authorizations

Open/In-Review Queue

# Prior Authorization System (PAS)



Home Page Application Pages Self Service Tool

## Avalon Employee Home

You are signed in as [DemoHealthPlan Supervisor](#).

-  [Authorization Request Form 12.1.2024](#)
-  [. Authorization Code List 12.18.24](#)
-  [PAS Provider Training Manual 2024](#)

## Home Page once logged into PAS

- MVP Health Care authorization request form
- MVP Health Care authorization code list
- PAS Provider Training Manual

# Prior Authorization System (PAS)

Prior Authorization Work Queue: Displays open-in-review or completed cases and where providers will submit their portal requests



Home Page Self Service Tool

Prior Authorization Work Queue

Prior Auth Search

Avalon Provider Portal

You are signed in as PAA DemoHealthPlan Provider

Welcome to the Avalon Provider portal! As an Avalon provider, you are a valuable member of the Avalon family and we rely on you to provide exceptional care to the members we serve. In order to do that, we are committed to providing you tools and information to assist you. A critical component of our toolset is our provider portal.


Currently, Avalon's provider portal provides the capability to request the status of your claims, download forms, check a member's eligibility, access your remittance advices and access other relevant documents.


If you have questions concerning this site, our provider service team is available to assist you. Please call 1-855-895-1676.

Prior Auth Search: Allows a user to search for member authorizations

# Open/In-Review Queue

This page will be the main screen providers will see when opening the Prior Authorization Work Queue. This page displays cases submitted by Providers within the last 60 days.



PAA Demo Health Plan P...

Home Page

Self Service Tool

Authorization Request

Open/In-Review (Last 60 Days)

Show 10 entries

Search Reference Number

Search Authorization Number

Search Member Name

Search Request Status

Search PA Determination

Search Create Date

Reference Number	Authorization Number	Member Name	Request Status	PA Determination	Created Date
<a href="#">70928</a>		JERRY CAT	IN-REVIEW	IN REVIEW	06/04/2025 11:07:21
<a href="#">70930</a>		BARNEY RUBBLE	IN-REVIEW	ADDL INFO	06/04/2025 12:41:31

Showing 1 to 2 of 2 entries

Create New

Previous

1

Next

This column will always be blank if case has not been completed

Displays request status (will always be In-Review)

Displays when the case was created


Displays case reference number as a hyperlink for easy accessibility

Displays member name

Displays if case is in review, needs additional information, etc.

All column headers have search capability for providers to drill down on a particular member for case status.


# Authorization Summary



Home PageSelf Service Tool

Authorization Summary

Documents

Test Pic.pdf

Authorization Request Detail

Click here to Expand/Collapse

Done

Disclaimer: A prior authorization is not a guarantee of payment. Payment is subject to member eligibility and benefits on the date of service.

Displays all documentation submitted by provider for medical necessity review

Displays case status during the review process and provides the case reference number

Displays case submission details once expanded



# Authorization Summary (cont'd)

Displays expanded view of case submission details including:

- A. Member information required for submission
- B. Ordering and Rendering provider information required for submission
- C. Diagnosis codes required for submission (*provider must submit at least one but can submit up to twelve*)
- D. Procedure codes with units required for submission (*provider must submit at least one but can submit up to fifty*)
- E. Clinical information required for submission (*must include physician's orders and clinical documentation to support medical necessity*)
- F. Providers can print a copy for their records if needed

Authorization Request Detail

Prior Authorization Details

Request Status

IN REVIEW

Member Information

Full ID Card Number

Member Name

Date of Birth

Date of Service

TC1111111109

JERRY CAT

03/28/1980

06/06/2025

Provider Information

Ordering Provider

Rendering Provider

NPI

1801963376

Address Line 1

Martin Luther King Jr Blvd

Provider Name

Russell Anderson

Speciality

Allergy & Immunology

Email

Phone Number

8137334826

Fax Number

8137334826

NPI

1669484473

Address Line 1

Martin Luther King Jr Blvd

TIN

111111111

Facility Name

MYRIAD

Email

Phone Number

8137334826

Fax Number

8137334826

Service Information

Diagnosis Code

Requested Procedure Code

Primary Diagnosis

A010.0

Description

Typhoid fever, unspecified

Procedure Code

81408

Description

MOPATH PROCEDURE LEVEL 9 (81408)

Z Code

Description

Units

2

Test Details

81323

Description

PTEN GENE DUP/DELET VARIANT (81323)

Z Code

Description

Units

2

Clinical Information

Documents

Test Pic.pdf

File name

Document type

Office/Clinic Notes including Physician's Order

Print

Done

# Provider Support

# Education, Self-Service and Continuous Support

## Broad Provider Education

- Policy publication/notification
- Prior authorization client list
- Program information distributed via provider communication channels
- Webinars/educational sessions with program information

## Self-Service

- Providers receive a step-by-step guide for navigation in the Preservice Authorization System (PAS)
- Providers can submit preservice review requests 24/7 through the PAS portal

## Ongoing Provider Support

- Account Client Services (ACS) Portal
- Provider Call Center at t **1-844-227-5769**
  - Agents are available Monday – Friday, 8:00 AM to 5:00 PM EST to assist with provider inquiries

## Peer to Peer physician support

- ✓ Nurse Reviewer support
- ✓ Consultations available both pre and post determination (including external review)
- ✓ Notice of determination available in each authorization

# Thank You

We hope that you found this information helpful

**Contact:** If you have any questions about this presentation, please contact your MVP Provider Relations Representative or your Provider Partnership Liaison

