Avalon Precision Genetic Testing Management (PGTM)

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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

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Program Overview

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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.

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PGTM Policies

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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

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PGTM Policies

MVP PGTM policies can be viewed by visiting **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

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Prior Authorization Process

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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

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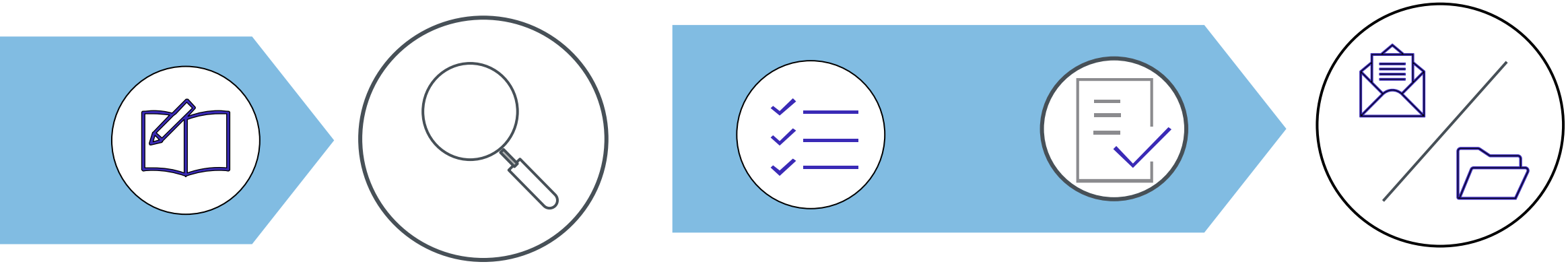
Process of Intake, Medical Necessity Review, and Notification

Precision genetic testing management process



Provider/PSR Team Submits Request

Intake Coordinator Verifies Case Validity

Nurse Reviews Coverage Criteria & Coding Parameters

Physician Reviews Coverage Criteria & Coding Parameters

Authorization Notification Sent to Member, Provider and MVP

Intake

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

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.

Provider/Member/HP Notification

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

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Diagnosis Exchange Registry

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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

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Portal Capabilities

Requesting Member Authorizations

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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.

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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.

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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

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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

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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*

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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

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Navigation of PAS for Providers

How to search for Member Authorizations Open/In-Review Queue

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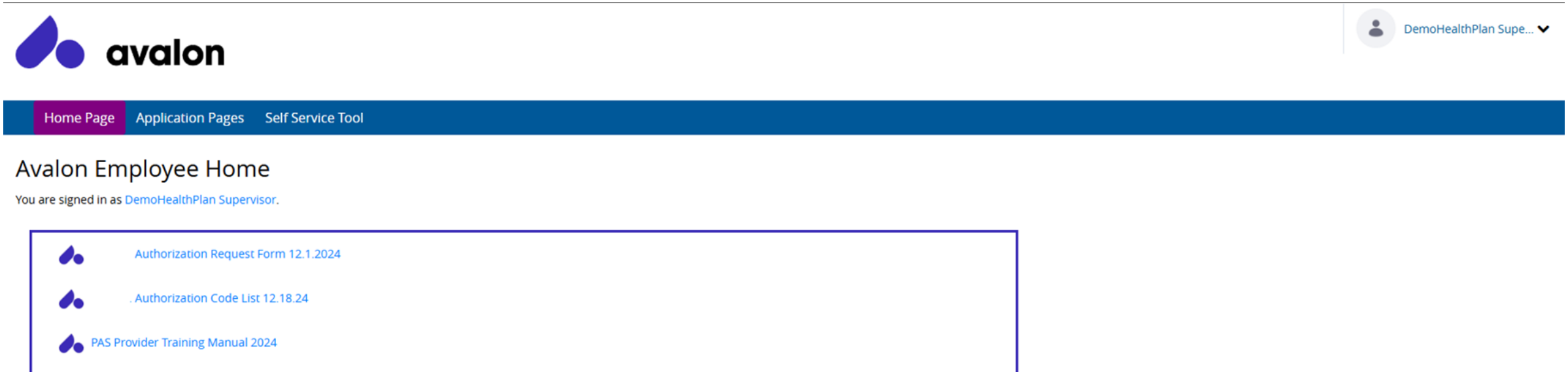
Prior Authorization System (PAS)



Home Page once logged into PAS

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

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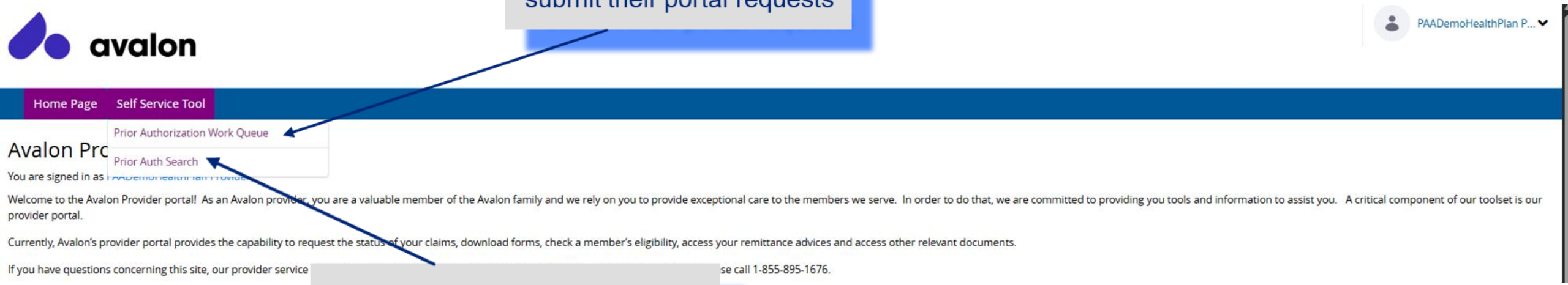
Prior Authorization System (PAS)

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



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

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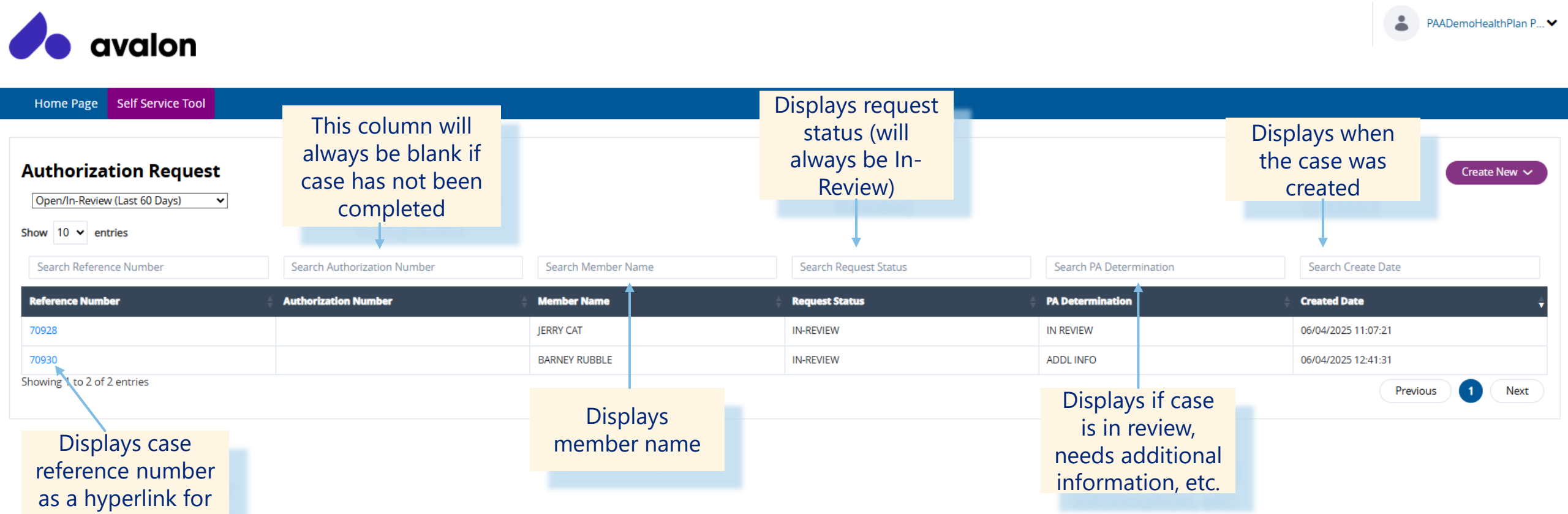
Open/In-Review Queue

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.



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

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Authorization Summary

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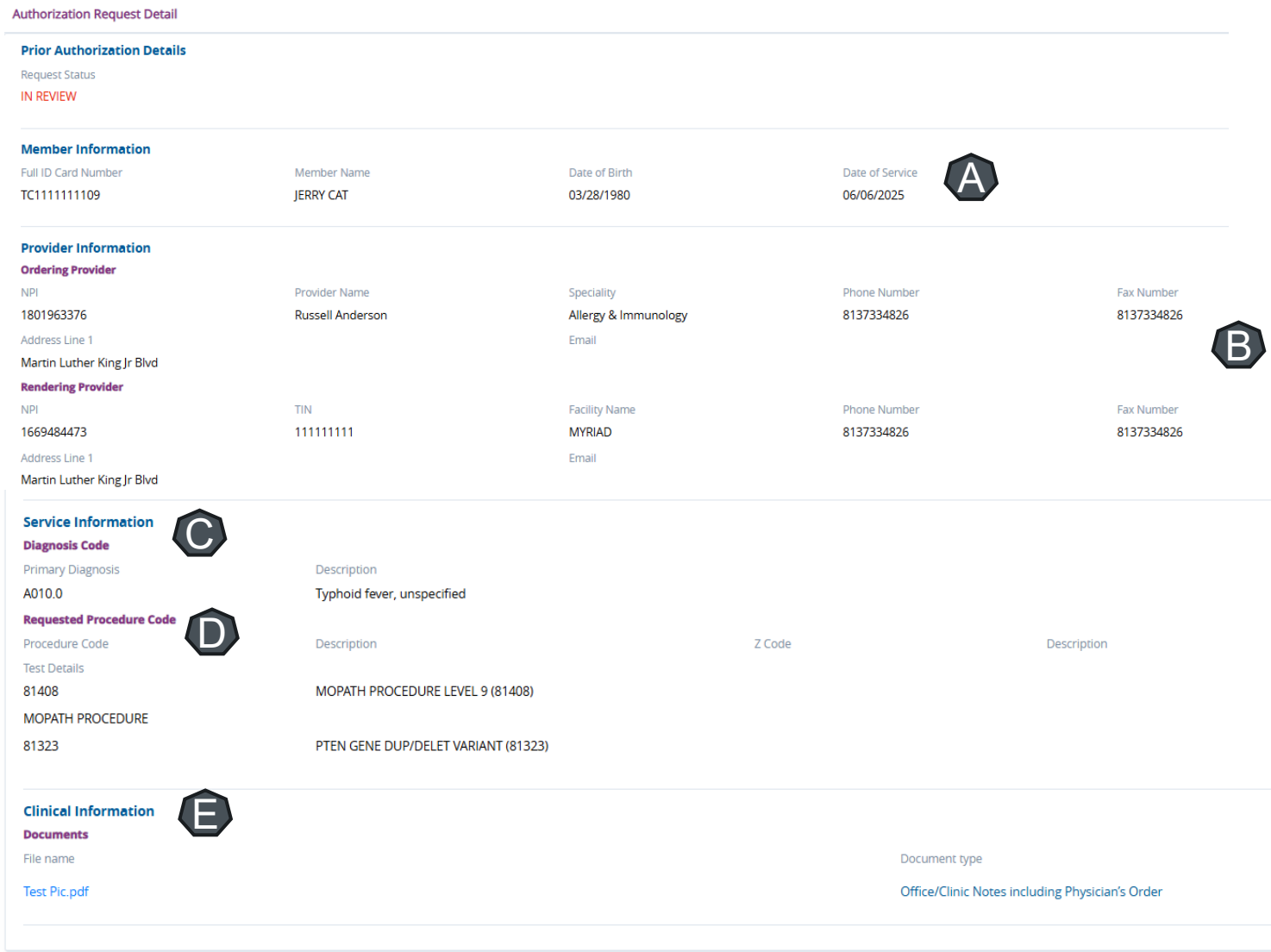
Authorization Summary (cont'd)



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

Provider Support

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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

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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

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