

Automated Authorization Provider Portal Process

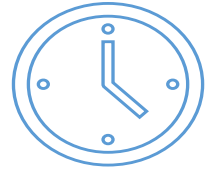
Updated June 2021 with new effective date.

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AUTOMATED AUTHORIZATION

- **What is Automated Authorization?**
 - It is a new functionality that will provide an instant approval response, when all the medical policy/guideline criteria is met, when submitting a prior authorization.
- **When?**
 - 6/7/2021 – Beginning with Epidural Spinal Injection (ESI) / Selective Nerve Root Block (SNRB).
- **Who does this affect?**
 - In-network providers who submit prior authorization requests through the Health Plan's Provider Portal.
- **How does it work?**
 - When submitting a prior authorization request in which there are Automated Authorization guidelines, you will be routed to complete a series of questions. If the guidelines criteria is met, you will receive an immediate approval. If the guideline criteria does NOT meet, the prior authorization will be assigned a status of "Submitted" and will be routed to the Utilization Management Department for further review and determination, following the current process.

BENEFITS OF AUTOMATED AUTHORIZATION



- Network Providers will have the opportunity to receive an instant approval if the medical policy/guideline criteria are met. Therefore, reducing the review process from up to 14 days (with manual review when all required medical documentation is provided) to within seconds.
- The Health Plan anticipates an increased member satisfaction, as members will benefit from a quicker prior authorization approval to be able to obtain their determination.

PROVIDER PORTAL

- Access the Health Plan's Provider Portal as you do today.
- Select Authorization Submit – complete steps 1 through 3.
 - Please note: If you currently attach clinical documentation, continue to do so.
- Step 4 is where you will notice the difference – launch CareWebWI.

Step 2: Select a member and classification.

Step 3: Complete detail fields.

Step 4: Document Medical Necessity

The next step in the authorization/referral request process is to complete the clinical questions related to the requested services in CareWebQI Auto Authorization. Once you complete the questions, you will be taken to the next step.

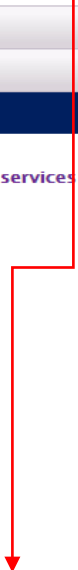
Select Primary Code

- 62323 – Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
- G5600 – Carpal tunnel syndrome, unspecified upper limb

[LAUNCH CAREWEBQI](#)

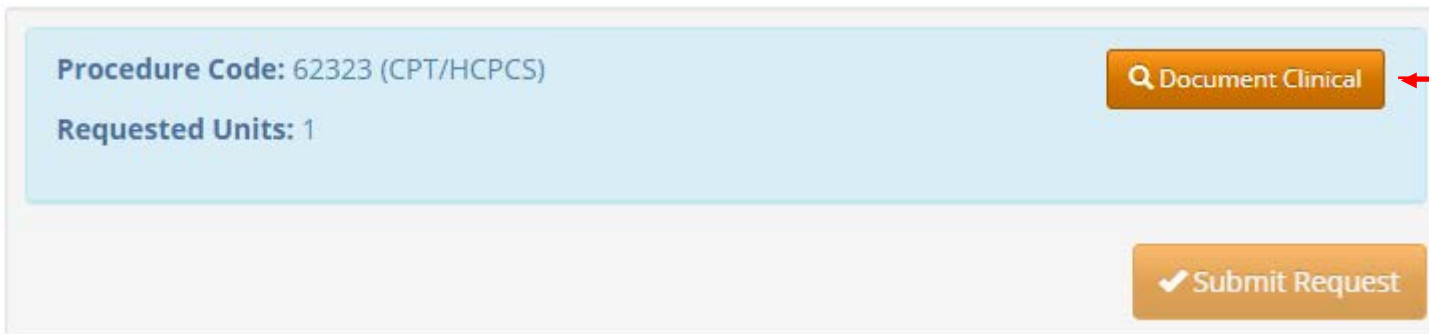
Step 5: Attach supporting documentation.

Step 6: View confirmation.



AUTHORIZATION REQUEST REVIEW: DOCUMENT CLINICAL

- A CareWebQI window will open. Click Document Clinical.



Procedure Code: 62323 (CPT/HCPCS)
Requested Units: 1

Document Clinical

Submit Request

A red arrow points to the 'Document Clinical' button.

CLINICAL DOCUMENTATION

- Go through the guideline criteria checking boxes where appropriate.
 - Where you see “...” this indicates there are additional criteria selections to choose from, then select Save.

Procedure Code: 62323 (CPT/HCPCS)
Requested Units: 1

DHSC ESI and SNR MP9362 - DHSC Epidural Steroid Injection (ESI) and Selective Nerve Root Block (SNRB) - MP9362 - (AC)

The procedure is/was needed for appropriate care of the patient because of ...

- Select procedure/service requested ...
 - Initial Epidural Steroid Injection may be indicated when ... are present:
 - Repeat Epidural Steroid Injection may be indicated when ... are met
 - Diagnostic selective nerve root block (SNRB) for identifying the etiology of pain in members with symptoms suggestion of chronic radicular pain ...
 - Therapeutic selective nerve root block (SNRB) for the treatment of chronic radicular pain when non-invasive measures such as physical therapy and medication have failed and ... have been met
 - At least two (2) weeks since previous SNRB
 - Less than or equal to three (3) SNRB's per level within six (6) month period
 - Is the servicing provider a plan provider? ...

SUBMIT AUTHORIZATION

- Submit Request

✓ Procedure Code: 62323 (CPT/HCPCS) show more

Requested Units: 1

✓ Submit Request

- Step 5: Attach supporting document if applicable. This step has not changed. Select Submit Auth Request

Step 2: Select a member and classification.

Step 3: Complete detail fields.

Step 4: Document Medical Necessity

Step 5: Attach supporting documentation.

Do you have supporting documentation to accompany this authorization request?

Fields in **bold** are required.

SUBMIT AUTH REQUEST

DETERMINATION = APPROVED

Step 6: View confirmation.

Thank you for submitting your Pain Management Injection Request. It has been assigned Reference ID [P210302012](#) with a status of "**APPROVED – Medically Necessary.**"

Disclaimers:

Benefits are determined in accordance with the eligibility and limitation provisions of your Benefit Certificate or Summary Plan Description.

Approval/Authorization

for medical necessity does not guarantee coverage and/or payment for services.

If you think a coding error may have occurred, you have the right to obtain the billing and diagnosis code descriptions associated with this request/service.

You can request this information by contacting Customer Service at 800-279-1302 or ASO Customer Service 877-234-4516.

Reimbursement for services rendered is subject to:

- Member eligibility must be verified for date(s) of service
- Service(s) rendered is a covered benefit
- Member is not eligible for other health care coverage
- Service(s) rendered do not require authorization
- Service(s) rendered are performed within effective date range of referral

DETERMINATION = SUBMITTED

- In the event your clinical documentation does not meet guideline criteria, you will receive an “Submitted” status.

Step 4: Document Medical Necessity

Step 5: Attach supporting documentation.

Step 6: View confirmation.

Thank you for submitting your Pain Management Injection Request. It has been assigned Reference ID [P210223003](#) with a status of “**Submitted.**”

Disclaimers:

This request is unable to be auto-approved. This prior authorization request will be routed to Utilization Management for the standard manual review process.

[SUBMIT ANOTHER REQUEST](#)

Reimbursement for services rendered is subject to:

- Member eligibility must be verified for date(s) of service
- Service(s) rendered is a covered benefit
- Member is not eligible for other health care coverage
- Service(s) rendered do not require authorization
- Service(s) rendered are performed within effective date range of referral

DETERMINATION

- Approved
 - Services are approved
 - Letter will be generated
- Submitted – will be sent to Utilization Management for further review
 - Possible Reasons:
 - Out-of-network servicing provider
 - Did not meet guideline criteria
 - May have requested CPT codes that do not require prior authorization

Approved

Submitted

PROVIDER RESOURCES

- The following information is available from the new [WellFirst Health Automated Authorization web page](#) for reference:
 - Automated Authorization Q&A
 - Link to the ESI/SNRB Medical Policy MP9362
 - ESI Checklist
 - SNRB Checklist
 - Link to register for the Health Plan's Provider Portal
 - How to contact your Provider Network Consultant