Avalon Frequently Asked Questions

Who or What is Avalon?

Avalon Healthcare Solutions is a laboratory benefits manager. Avalon works with health plans to offer a comprehensive suite of laboratory benefit management services, including laboratory utilization policies and routine testing management. Avalon's goals are to:

- Increase access, quality, and affordability of laboratory care
- Empower patients to navigate their care with transparency tools
- Support physician/patient relationships
- Enhance the patient healthcare experience

How Will this Change impact Select Health-Contracted Providers?

Laboratory providers/vendors will not be reimbursed for services if appropriate ICD-10 codes were not used to justify the laboratory test request.

Why is Select Health Contracting with Avalon?

Avalon's Laboratory Benefit Management Program promotes appropriate testing, which helps drive quality and cost-effective medical care. Members receive the right test at the right time.

What are Avalon's Standard and Ad Hoc Reports Capabilities?

Avalon provides:

- Flexible reporting capabilities that routinely identify outlier ordering patterns and physicians.
- Impact analyses, which can be used to compare laboratory test utilization relative to health plan clinical and payment policies.

Through their reporting, ordering physicians can be educated and outlier activity can be shared with more clinically compliant laboratories.

Is Avalon National committee for Quality Assurance (NCQA) Accredited?

Yes, Avalon is NCQA accredited for Utilization Management and all Avalon processes and policies comply with Select Health requirements and state DOI regulations. Avalon has also successfully completed multiple health plan UM delegation audits.

Are These Policies Created by Avalon or Select Health?

Avalon helps to develop Select Health laboratory utilization policies. Avalon developed and proposed many of these policies, leveraging their independent Clinical Advisory Board of recognized experts in laboratory science. These laboratory utilization policies have also been reviewed by corresponding Intermountain Healthcare specialists and modified accordingly to align with Intermountain Healthcare needs and protocols.

Where do I Find the Current Select Health Laboratory Medical Policies?

There is a Laboratory Medical Policies booklet that can be viewed and downloaded from the Policies area of our provider website (no login required) or as individual policies that are searchable on the Select Health secure Provider Portal (login required).

Why Doesn't Avalon list CMS Diagnosis Codes on Each Policy?

While procedure codes are included in section VII of each policy, the combinations of procedure codes and diagnosis codes are complex and may vary across other criteria, such as patient age. The provider should understand the medical necessity for policy adherence and perform the test when appropriate. It is important that providers code accurately.

Why are the Allowed Units Less in Avalon's Proposed Policy than in a CMS Policy (e.g., flow cytometry)?

Medicare national and local coverage determinations (NCDs and LCDs) change infrequently. Avalon's Clinical Advisory Board meets quarterly and reviews each Avalon base policy at least annually. When Avalon base policy is updated, Avalon presents those updates to Select Health. Select Health policy professionals review the latest science and update the Select Health policy as appropriate.

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Avalon FAQ (continued)

What is the Avalon Process to Create a New Lab Policy?

The process to develop new and revise existing scientific lab policy has four basic steps: identify need, assemble information, vet content, and secure client approval.

Sources used to identify the need for a new or revision to an existing policy are various, including health plan utilization data, position statements from professional medical societies, and publications from entities recognized as leaders in evidence-based health care research, such as the National Comprehensive Cancer Network (NCCN).

Once we confirm the benefit of creating or revising a policy, we query appropriate literature sources to derive relevant content for documenting:

- The clinical condition/lab test being addressed by the policy (Definition)
- Why the test is important to consider, given the clinical condition (Background)
- Recommendations from credible sources that currently exist to advise on the appropriateness of testing (Guidelines)
- When testing is/is not considered appropriate, provided as medical necessity criteria (Indications/limitations of coverage)

Once created, the policy is presented to the Avalon Clinical Advisory Board. Once approved from the scientific, evidence-based standpoint, the policy is presented to Select Health for consideration.

How are Providers Notified about Changes to These Policies?

Changes to Select Health policies are communicated to Select Health providers through monthly policy update bulletins posted online and provided via the network notification process. Policies are also published on the Select Health website. If there are significant changes, Select Health may decide to communicate more proactively. Avalon is available to support provider communication efforts.

What Types of Policy Rules will APEA Administer?

APEA performs several types of edits:

- Mutually exclusive procedures
- Prerequisite procedures (add-ons)
- Unit limits on a single date of service (within and across claims)
- Unit limits over a period (e.g., 15 units permitted per 3 months)
- Frequency between procedures (e.g., minimum of 14 days between tests)
- Appropriateness of the clinical situations (i.e., analysis of all diagnosis codes on the claim)
- Experimental and investigational edits
- Demographic edits (limitations on age and gender appropriateness of testing)

Is There a Tool Available to Understand How APEA May Impact a Claim?

Avalon has developed a Trial Claim Advice Tool that allows you to input the procedure codes and diagnoses to determine how APEA will review the claim.

Providers will be able to access this tool by clicking on the icon at right on the Select Health secure Provider Portal (login required).

Will APEA Ever be Used for Pre-service Determination/Authorization Denials?

No, the APEA technology is utilized post service in the evaluation of laboratory claims.

Does Avalon Review all Diagnoses on a Claim?

Yes, APEA reviews all diagnoses on a claim.

How Do I Know a Denial is Correct if the Diagnosis Codes are Not on the Policy?

Diagnosis codes are a representation of the patient's condition. The policy describes the conditions that are appropriate (or inappropriate) for various tests. Accurate coding will ensure proper claim adjudication.

What is the Process for Reviewing Claim Appeals? Does APEA Include Handling Claim Appeals from Members and/or Providers?

Appeals and reconsideration requests remain the responsibility of Select Health; the current process as described in the Select Health Provider Reference Manual will not change.

Select Health