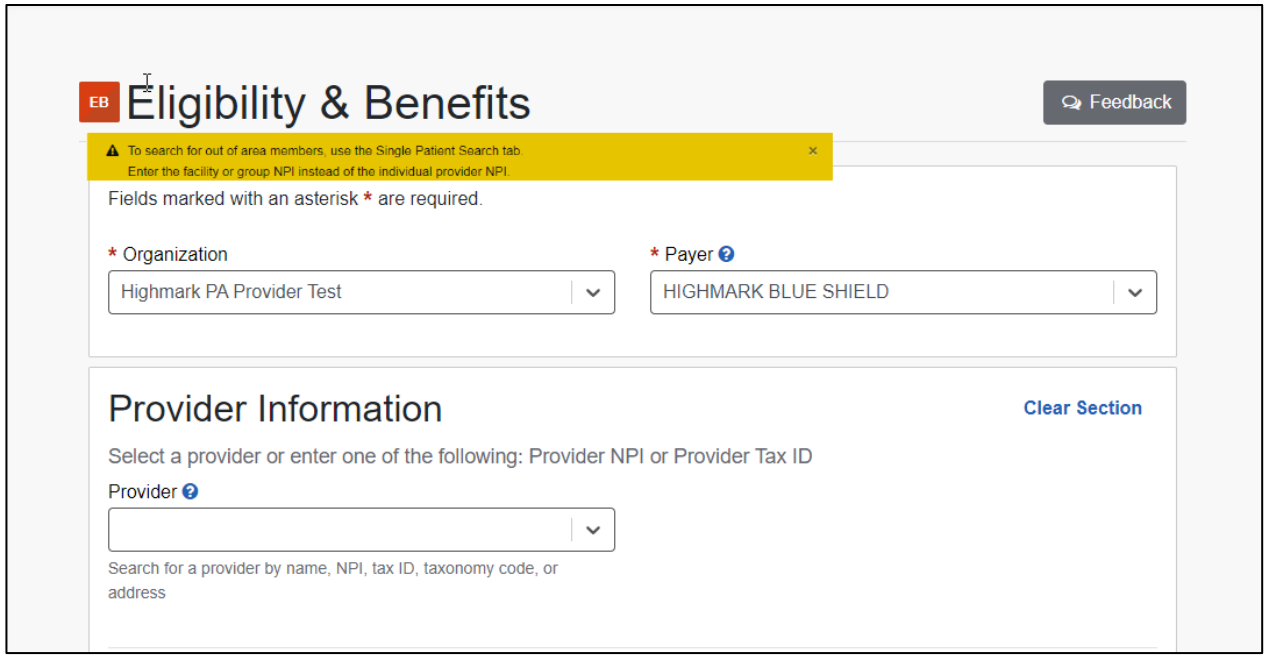
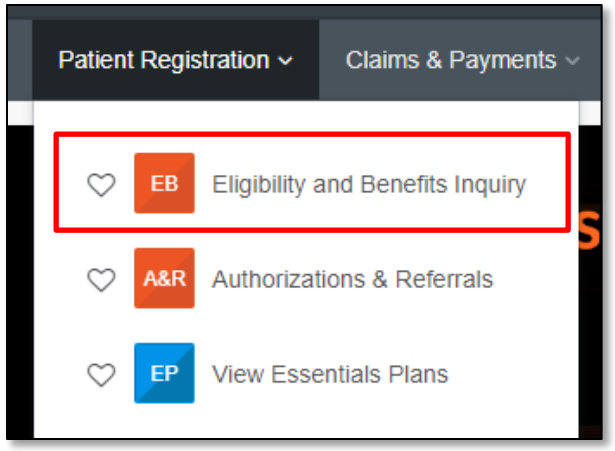
Availity® Provider Portal Inpatient Authorization Submission

Prior to submitting a prior authorization request, you should first check the member's Eligibility and Benefits, including authorization requirements. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service.

To do so in Availity, go **to Patient Registration** in the menu bar and click on **Eligibility & Benefits Inquiry**.

Complete the form, including Provider, Member and Service Information.

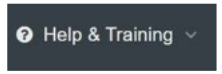




*Verifying Eligibility and Benefits prior to submitting a prior authorization request and/or submitting a claim can:

1) Help you avoid submitting unnecessary prior authorization requests
2) Confirm patient copays and/or coinsurance
3) Minimize claims rejections

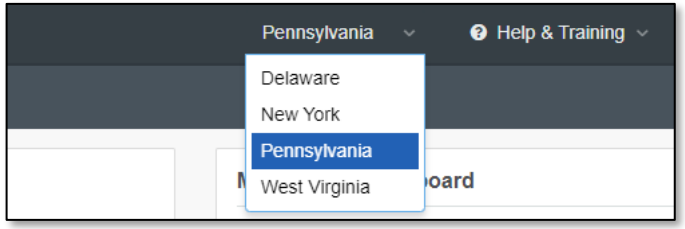
For additional assistance on Eligibility & Benefits Inquiry in Availity, go to Help & Training in Availity Essentials.



Submitting the Prior Authorization Request

In Availity Essentials, there are two paths for prior authorization submission.

After logging into Availity, first choose the appropriate state for your practice/facility.



Next, choose your authorization path:

Path 1	**Path 2**
Predictal via Payer Spaces	Authorizations & Referrals

Authorization Status / Authorization Inquiry:
Only Available via Path 1:
Predictal via Payer Spaces

Exception 1:
Retail Pharmacy Authorization Submissions
Can ONLY Use Path 1

Exception 2:
Out of Area (OOA) Member Authorization Submissions
Can ONLY Use Path 2

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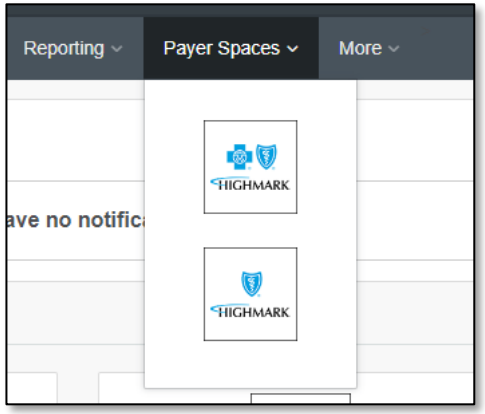
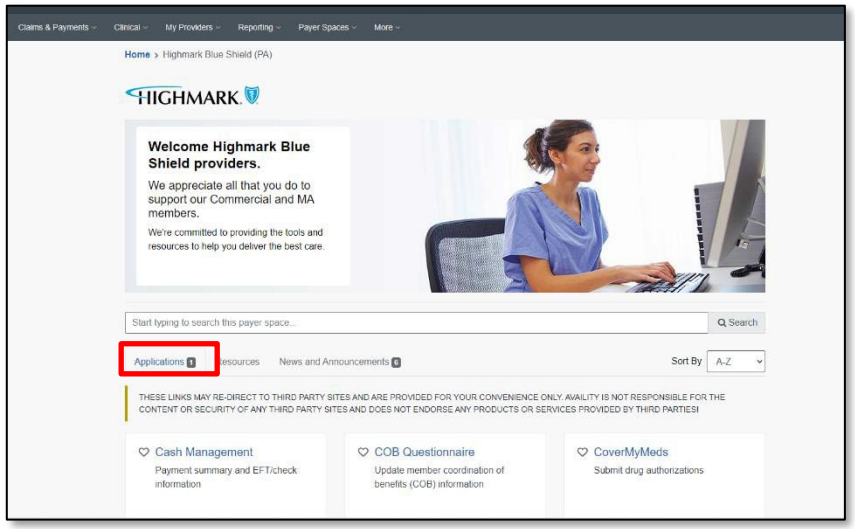
Path 1

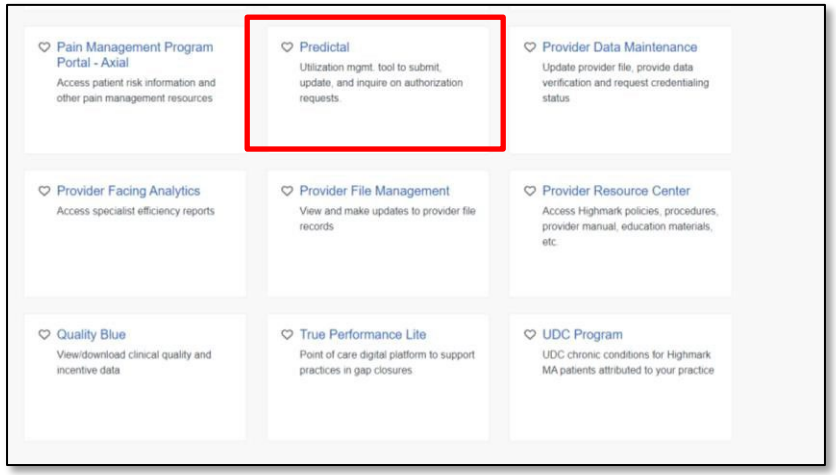
To access Highmark's Payer Spaces in Availity Essentials, click on **Payer Spaces** from the top menu and choose the appropriate Health Plan.

***To check Authorization Status and/or submit an Authorization Inquiry, you must use this path to access Predictal via Payer Spaces.**



Within **Payer Spaces**, look under **Applications** and select **Predictal.**





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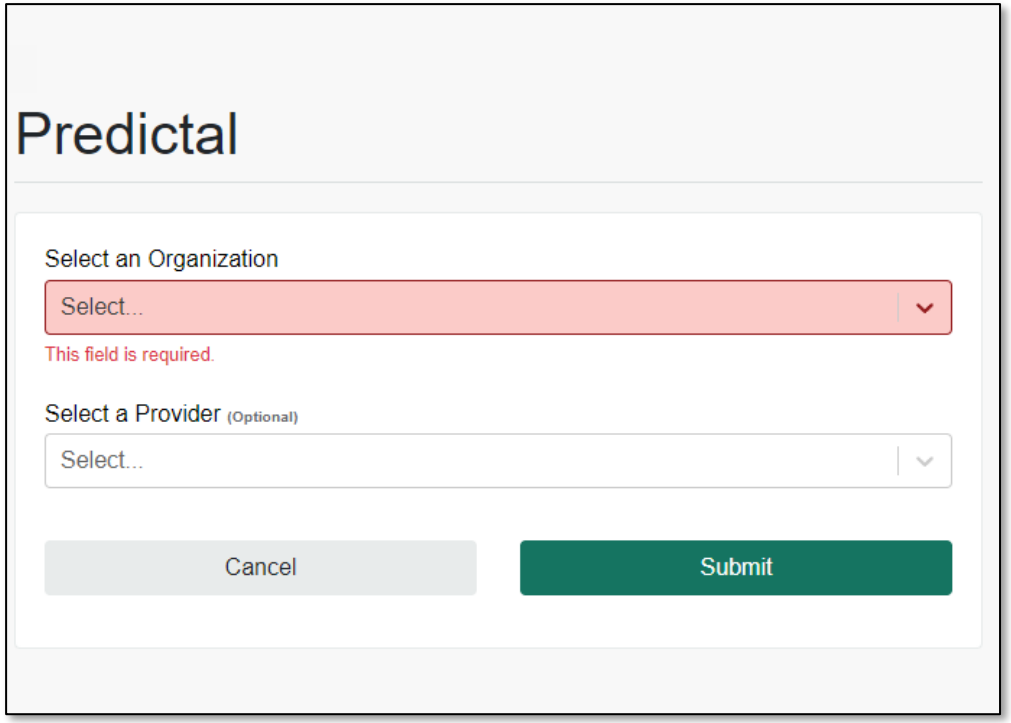
Path 1

Once you've selected Predictal, you will need to choose your **Organization**.

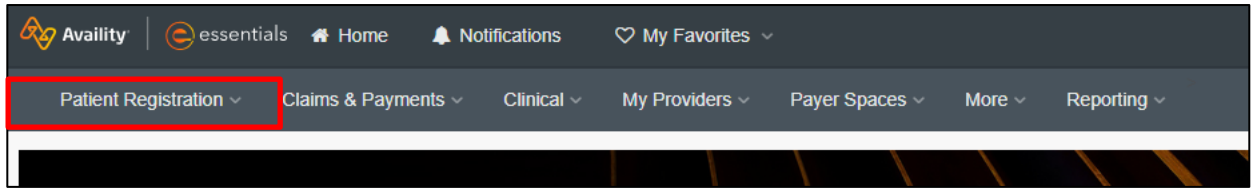
- Select a **Provider** (optional)
- Click **Submit** to get to a new tab.



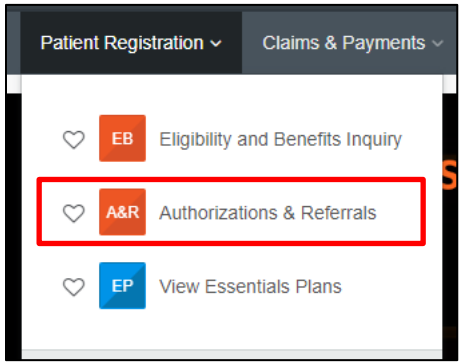
That will take you into the Predictal Authorization Automation Hub to complete your prior authorization request.

Path 2

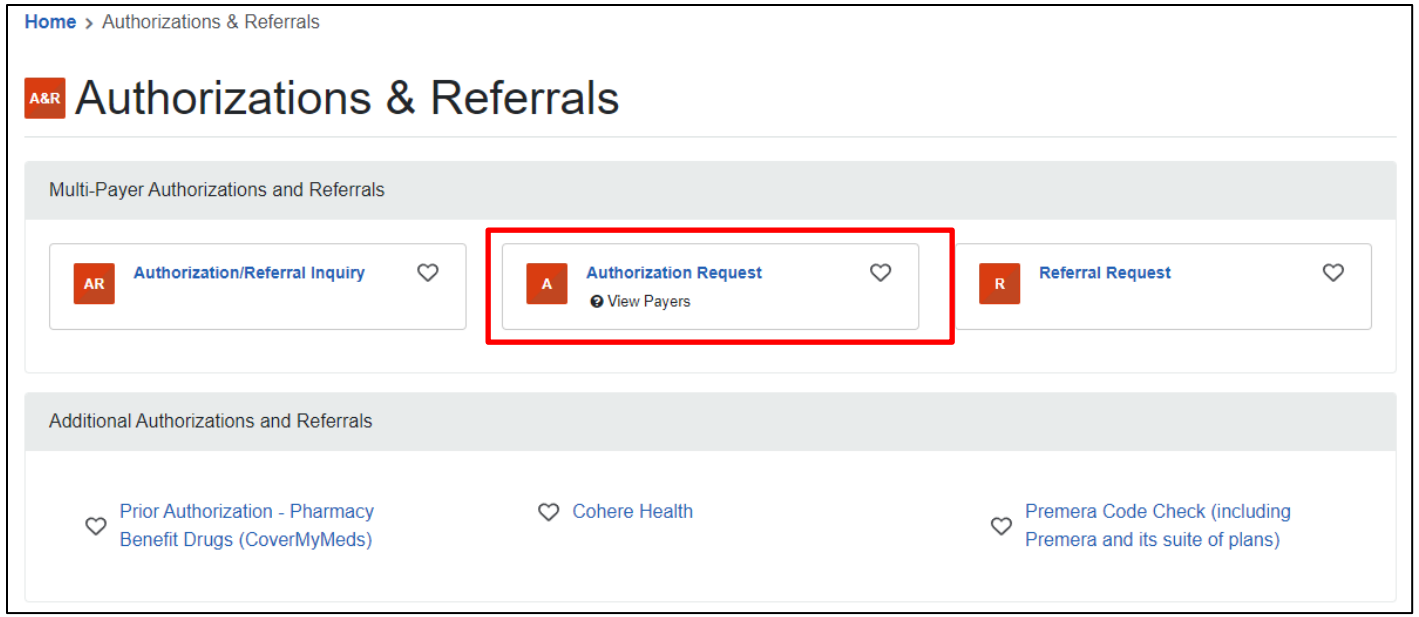
To access Authorization & Referrals, first click on Patient Registration in the top menu.



Then choose Authorizations & Referrals.



And select Authorization Request.



***For prior authorization requests for Out of Area members, you must use this path for submission.**

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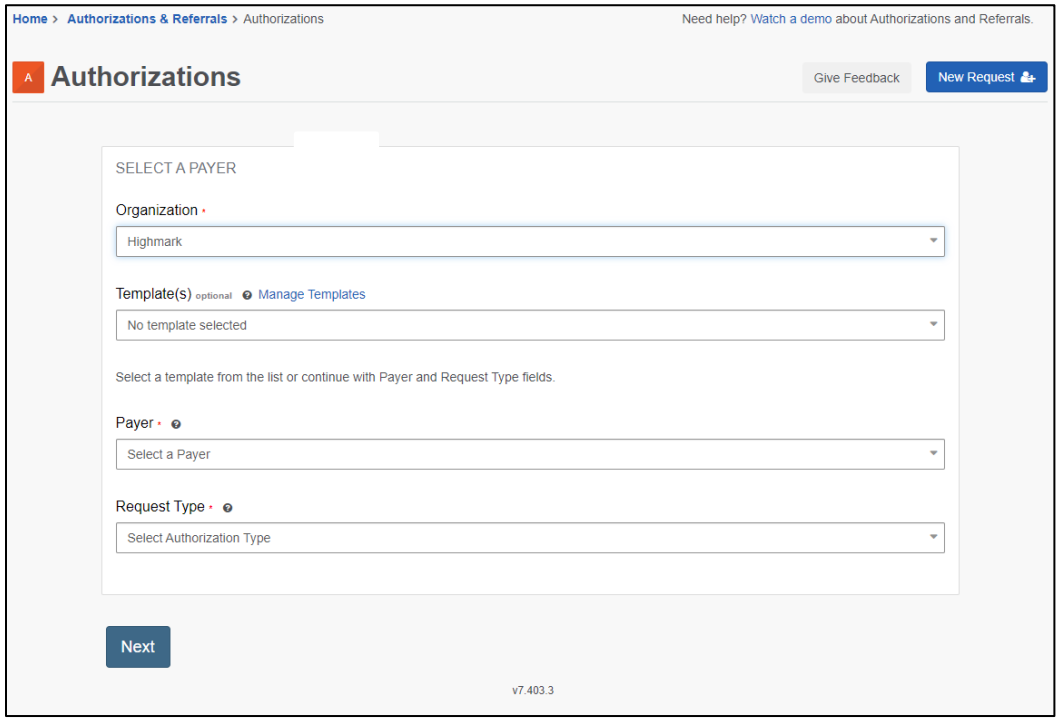
Path 2

Once you've selected Authorization Request, you will fill out the form with the appropriate information.

Additional fields will appear as you begin to complete the online form.



Predictal Auth Automation Hub

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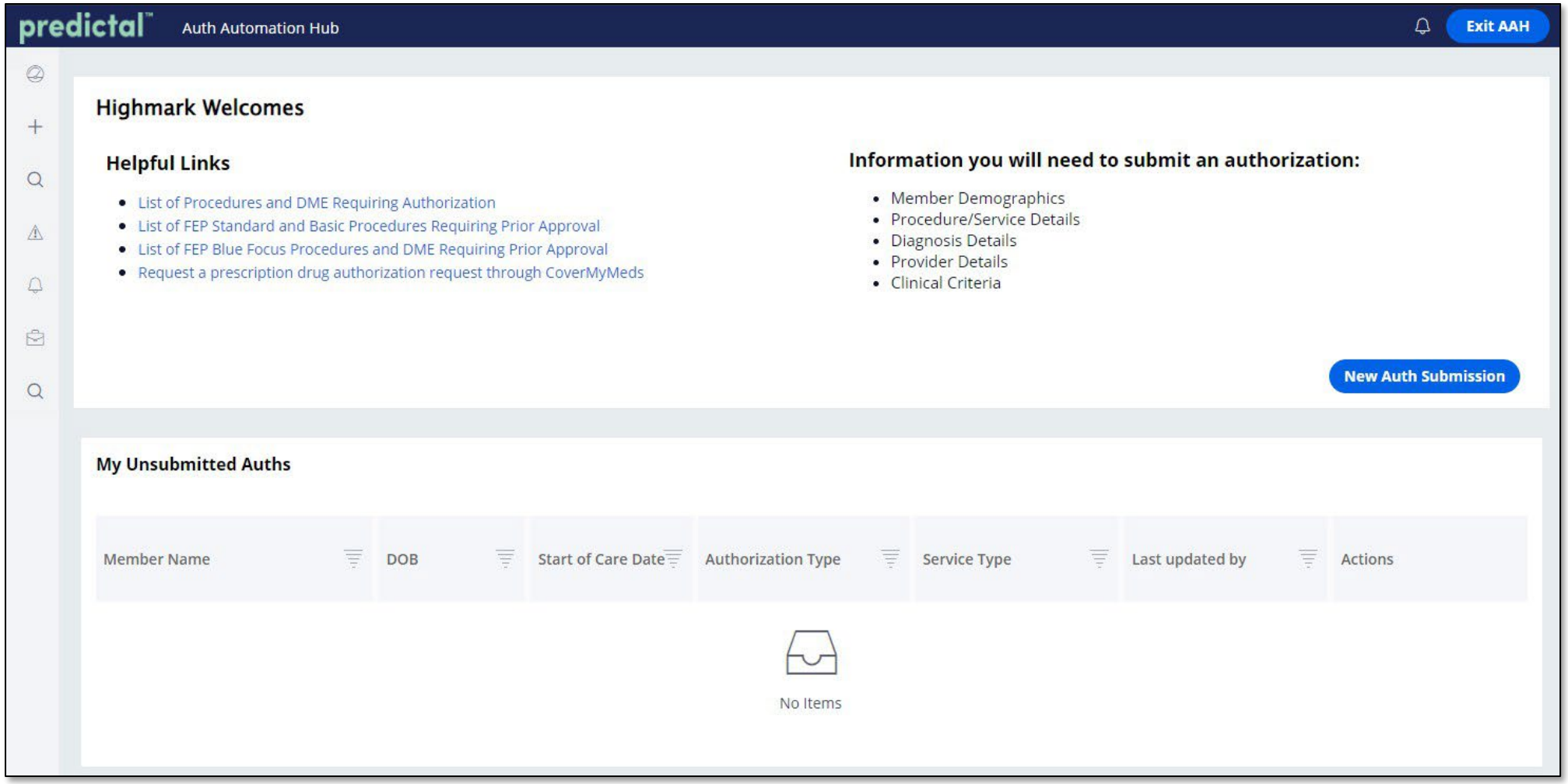
The Predictal home page has links to the Prior Authorization List, Cover My Meds submission, and a view into authorizations that have not been completed.



The left side navigation panel includes links to the functions available within Predictal.

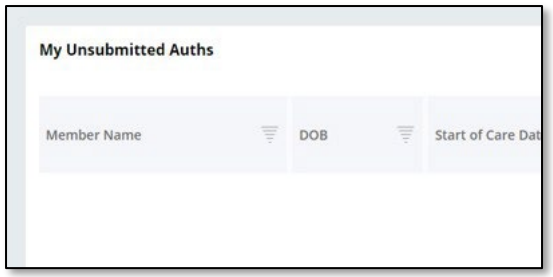
Select **New Auth Submission** to initiate a new request.

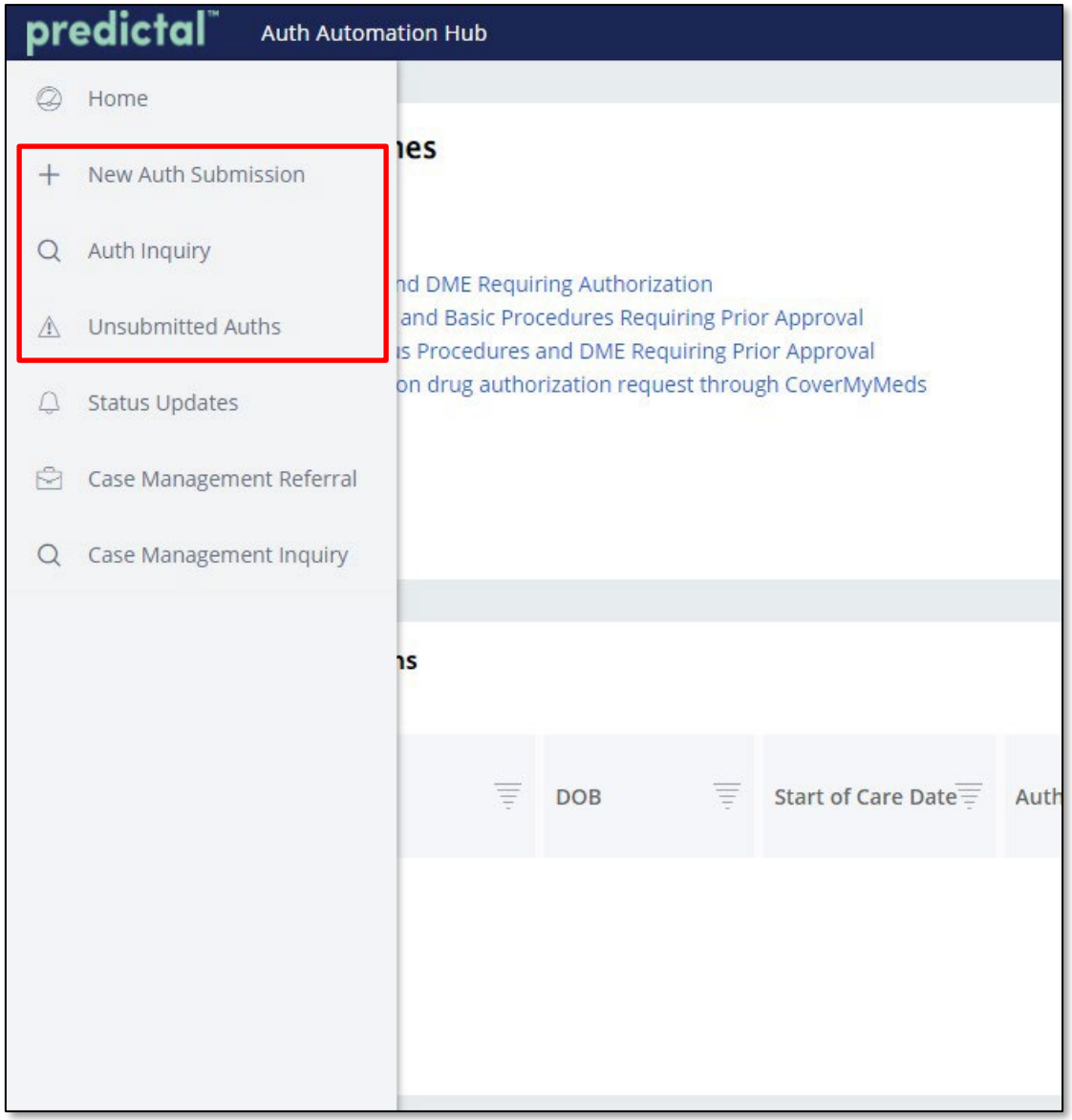
Select **Auth Inquiry** to do any of the following:

1. Check Authorization Status
2. Change/Update Start of Care Date
3. Review Approval and Denial Letters
4. Discharge Planning
5. Concurrent Review
6. Respond to a Request For Additional Information

Select **Unsubmitted Auths** to view an authorization request that was started but not yet submitted.

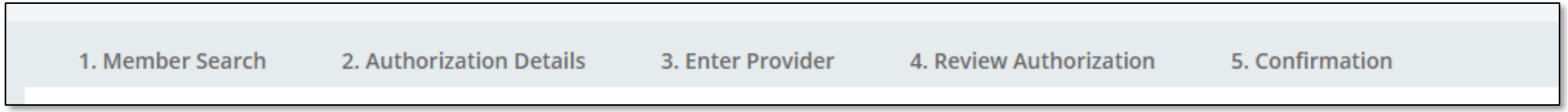
You can also view your **Unsubmitted Auths** on the Predictal homepage.





New Authorization Submission

The top menu bar in the Predictal Auth Automation Hub will walk you through the steps of the electronic authorization submission process.

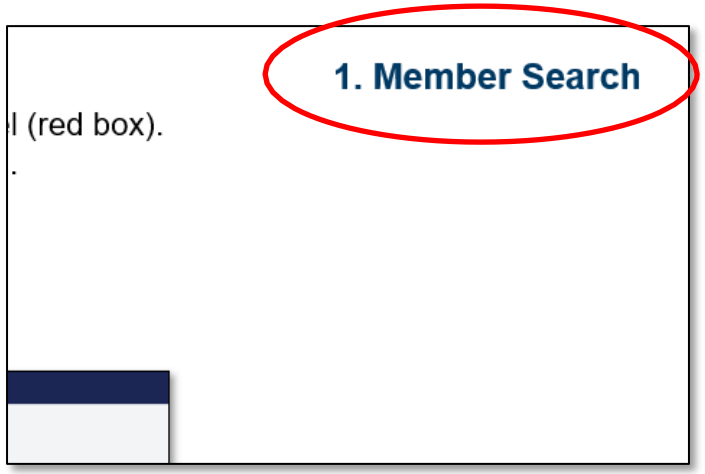


After each step listed in the top menu bar, you will be asked to hit **Submit**. Your authorization will not be submitted to Highmark until the final **Submit** on the Confirmation screen (Step 5 above.)

Throughout the authorization process, you will have the opportunity to **Save** your work without submitting. Hitting **Save** at the bottom of the screen will move the authorization request into your **Unsubmitted Auths** queue.

There is also a **Back** button that will allow users to go back and make any corrections to information that is incorrect.

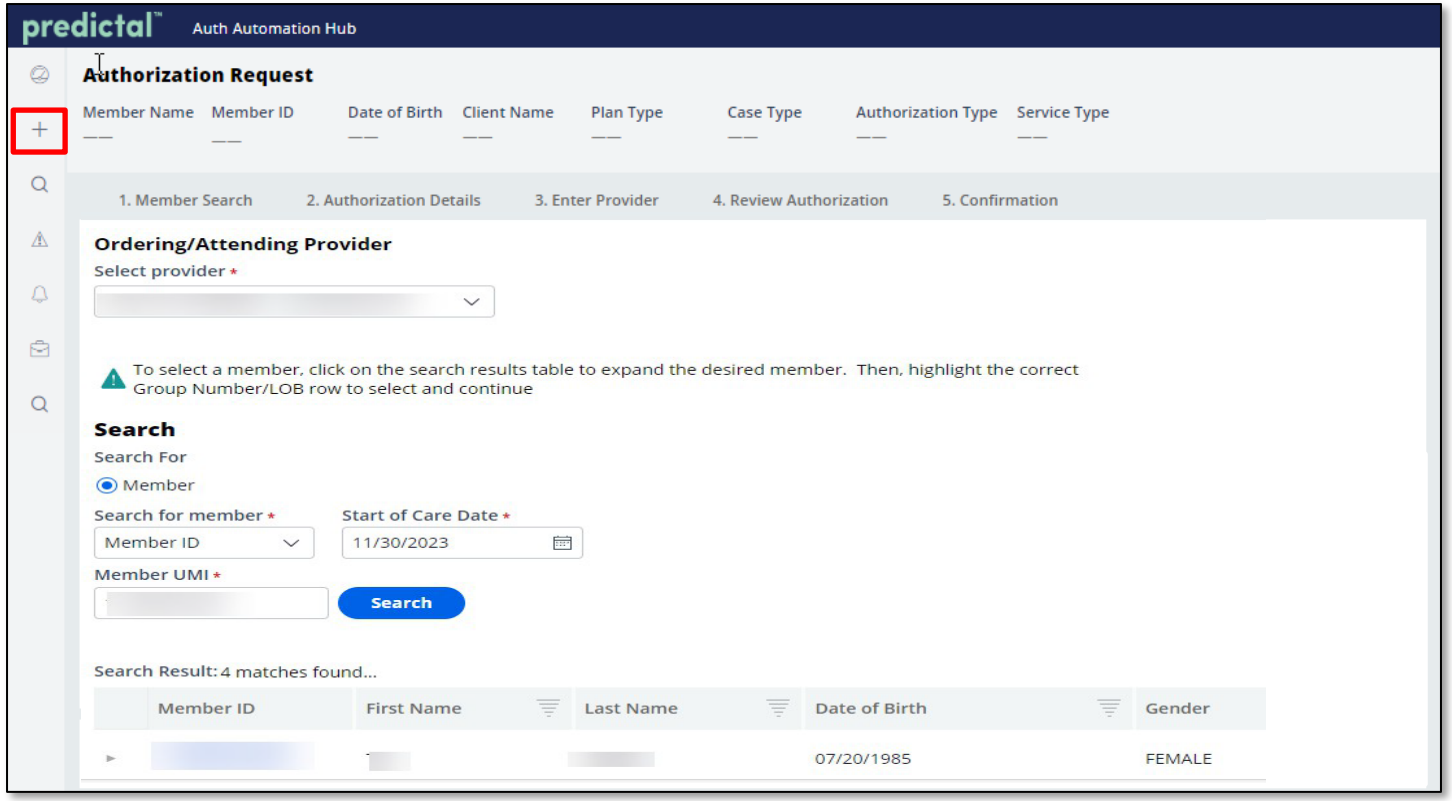
In the upper right-hand corner of the following slides, we've noted where you are in the submission process.



For a new Authorization Request:

1. Select **New Auth Request** from the left side navigation panel (red box).
2. Select the **Ordering/Attending Provider** from the dropdown.

Search the Member ID.
Fill in the Start of Care Date.
Select Search.



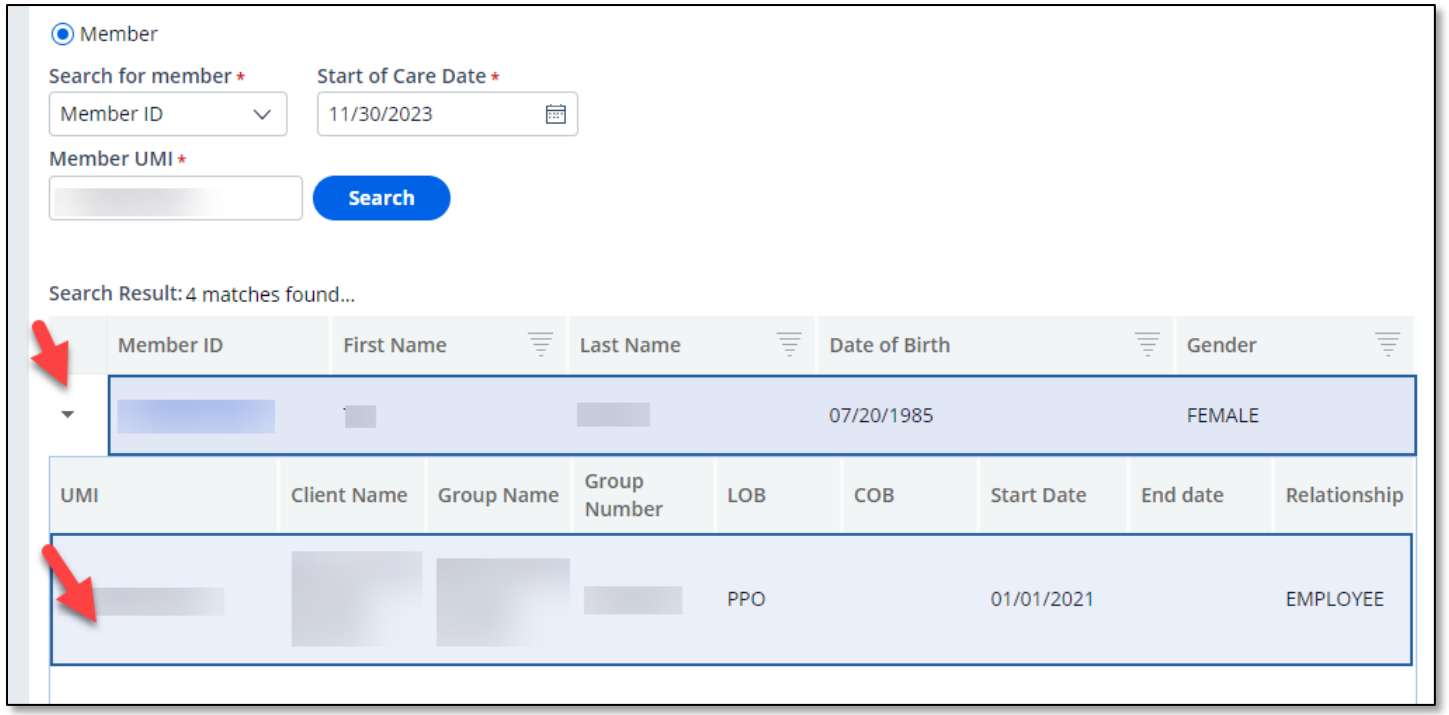
1. Member Search

When results return, to select the appropriate member, you will need to complete the following steps to select the specific member.

- Click on the **widget** to highlight the **member** and open the **additional information** about the member.
- Click on the **member** you wish to submit an authorization to highlight the row.

Doing this will select the member on the policy that the authorization will be submitted for.

You can then select **Submit** to move to the next step.

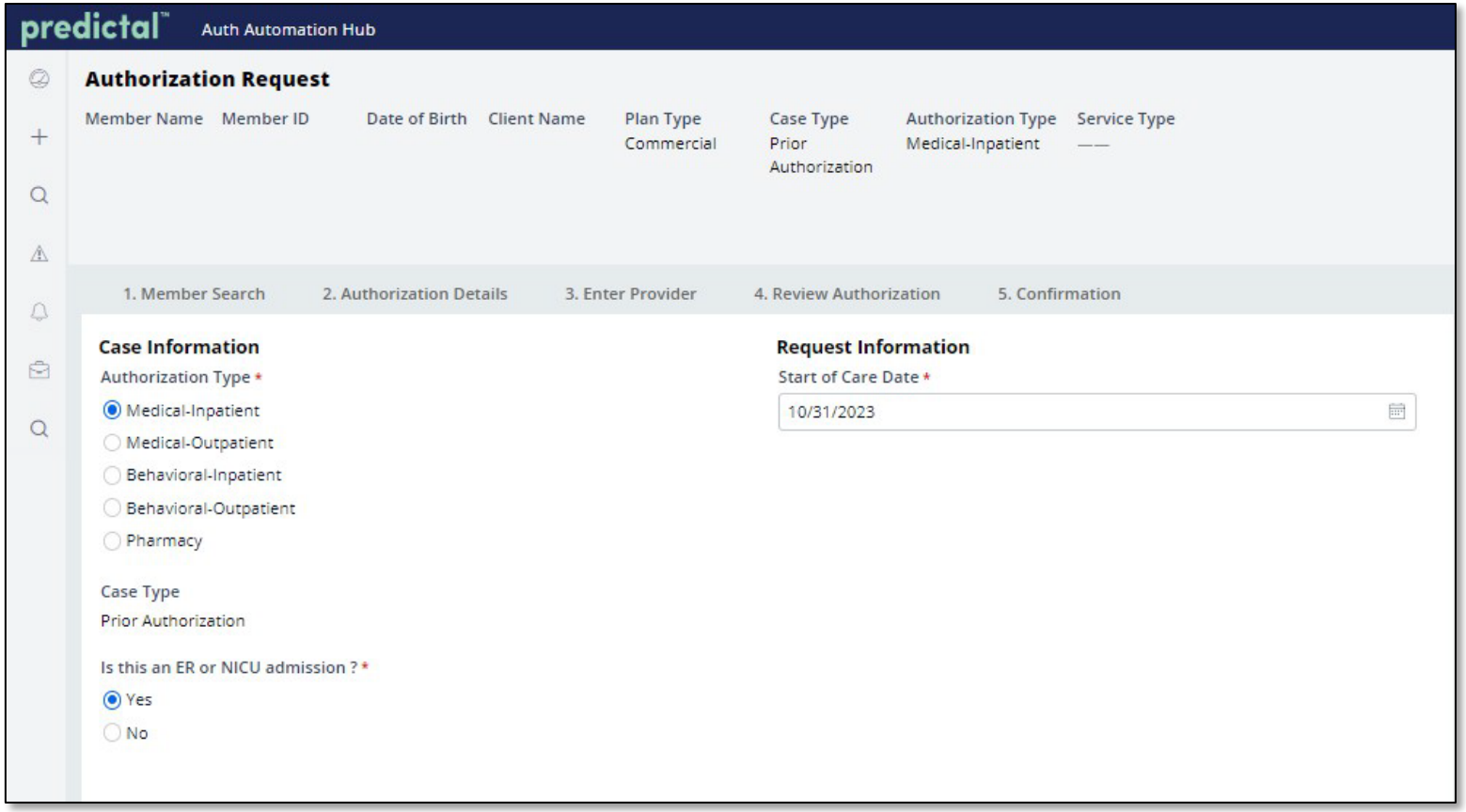


2. Authorization Details

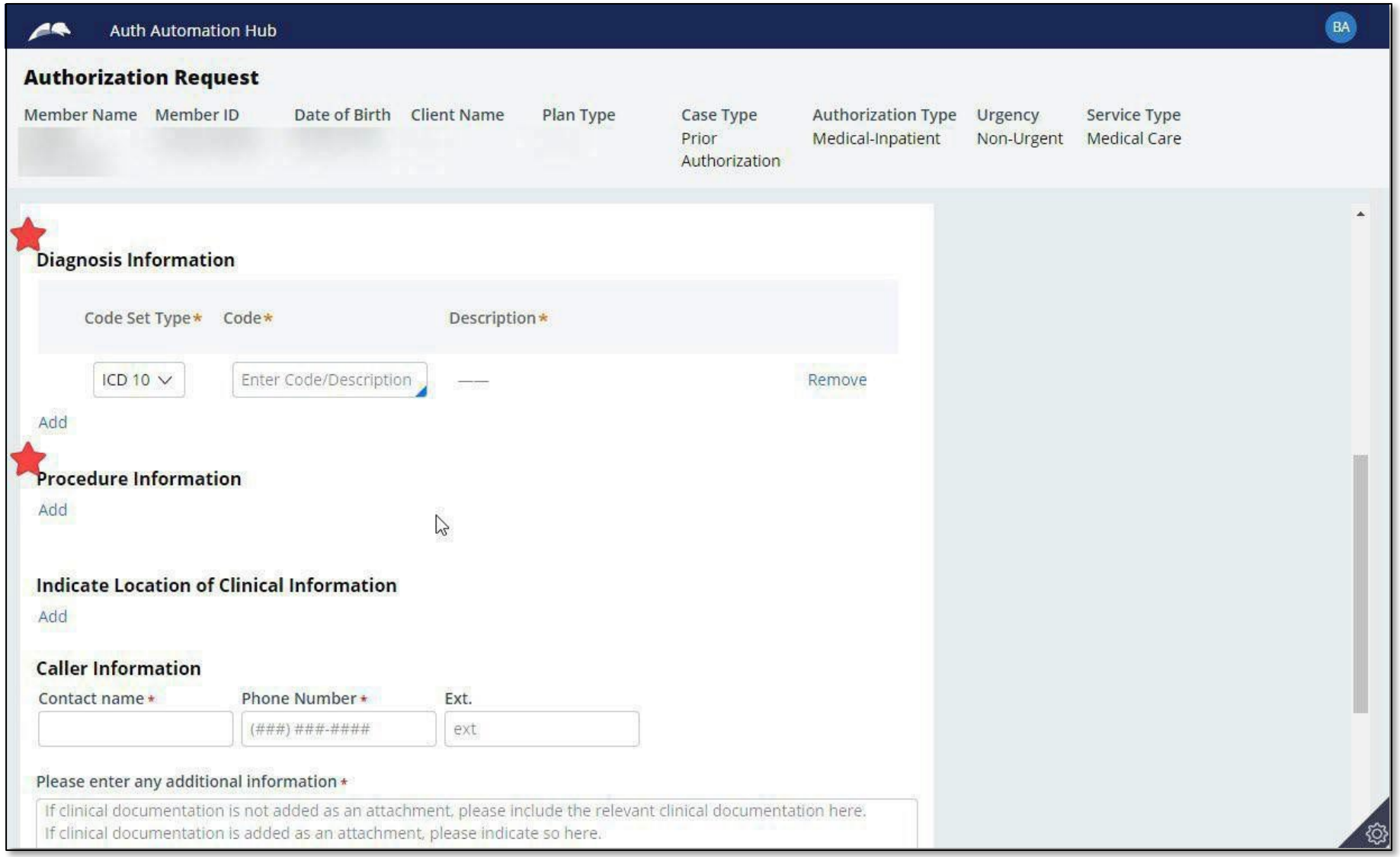
After you have completed the member information, can you move on to the following steps:

3. Select the Authorization Type
4. Select the Place of Service
5. Select the Service Type

Fill in the appropriate case information and indicate if this is an Emergent or NICU admission.



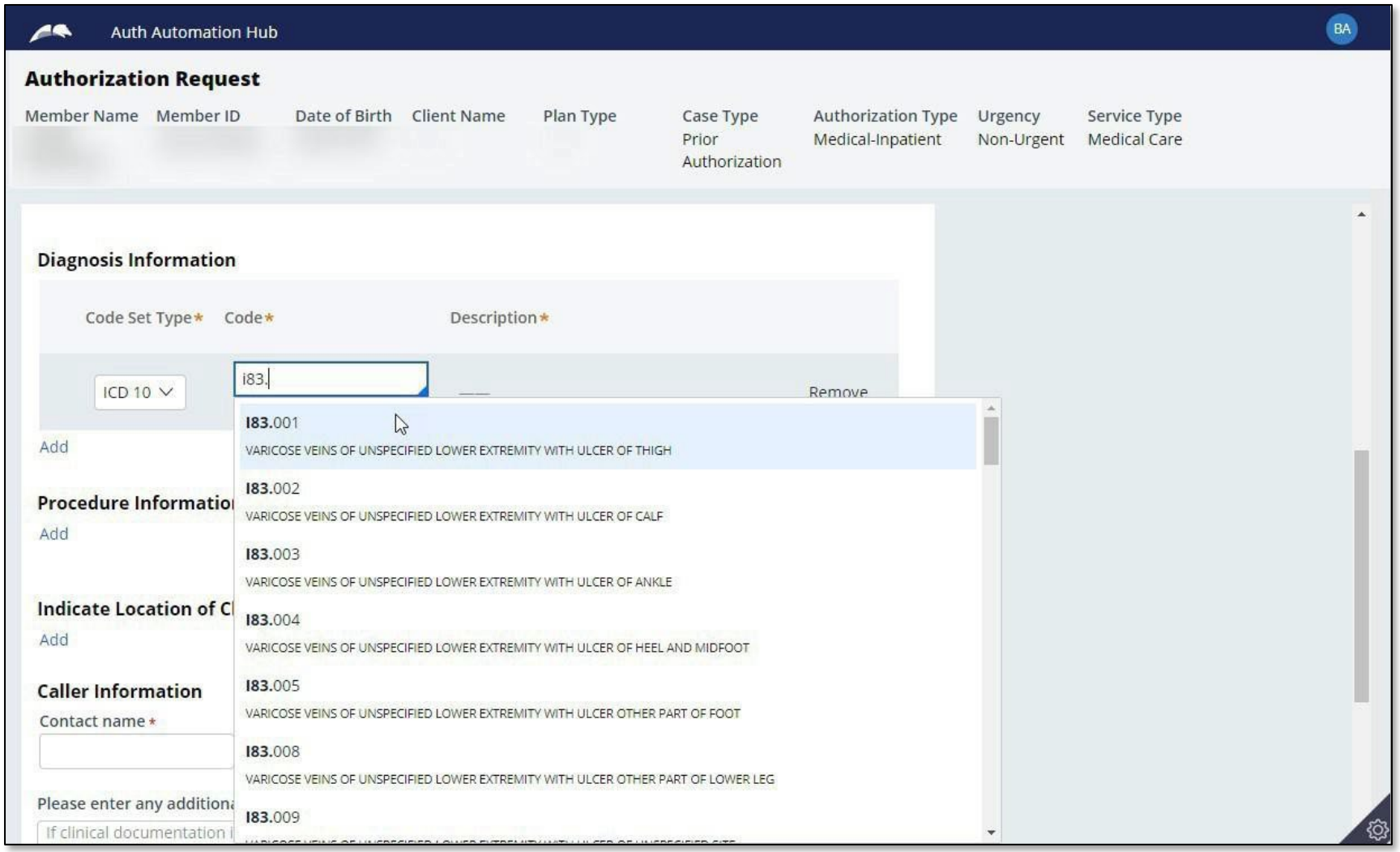
As you scroll down on the page you will completethe **Diagnosis Information**and **Procedure Information.**



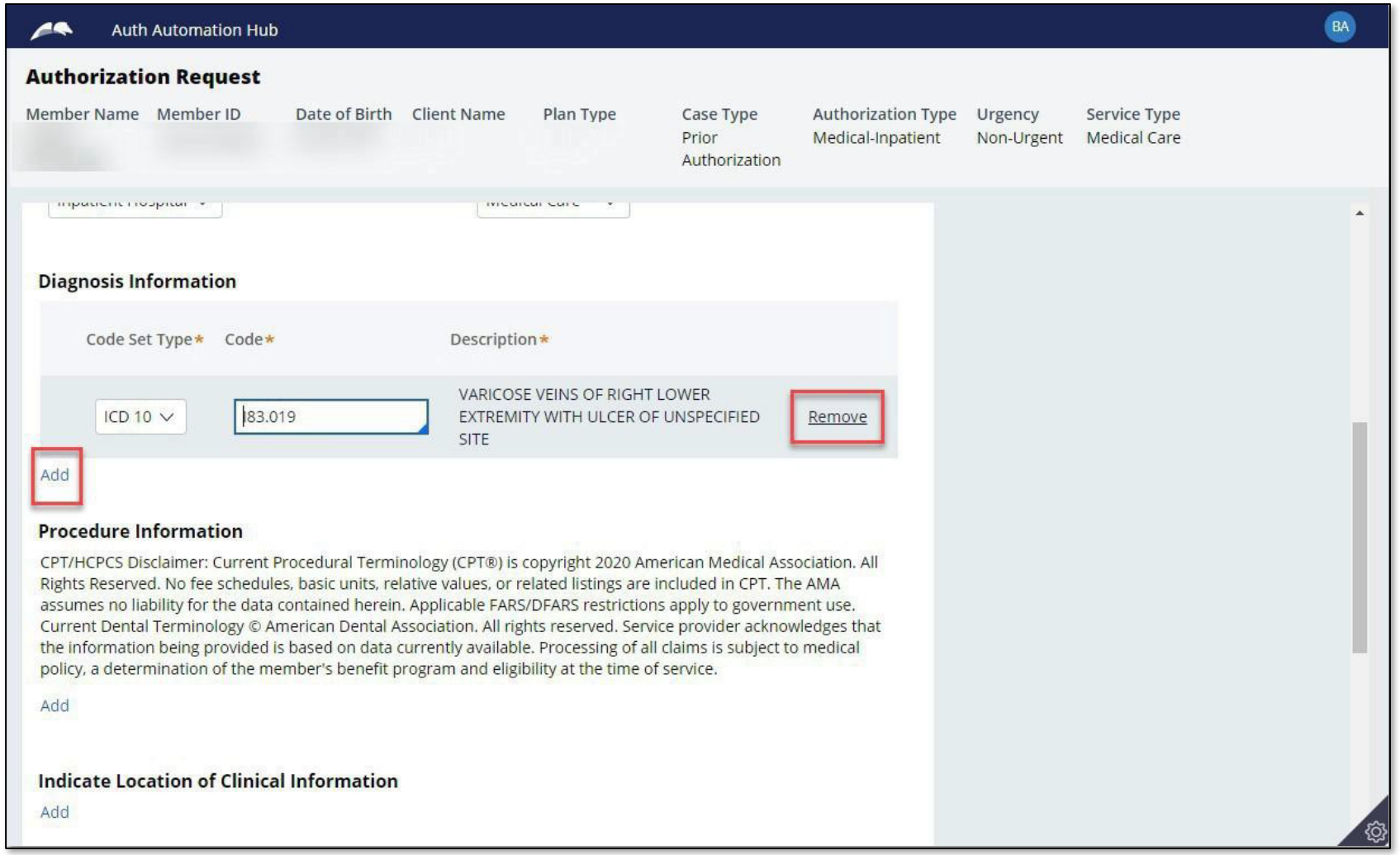
The type of authorization you are seeking will determine whether the **Procedure Information** is a required field.

Note: Procedure codes are NOT required for an inpatient urgent authorization request; however, they are required for inpatient planned admissions.

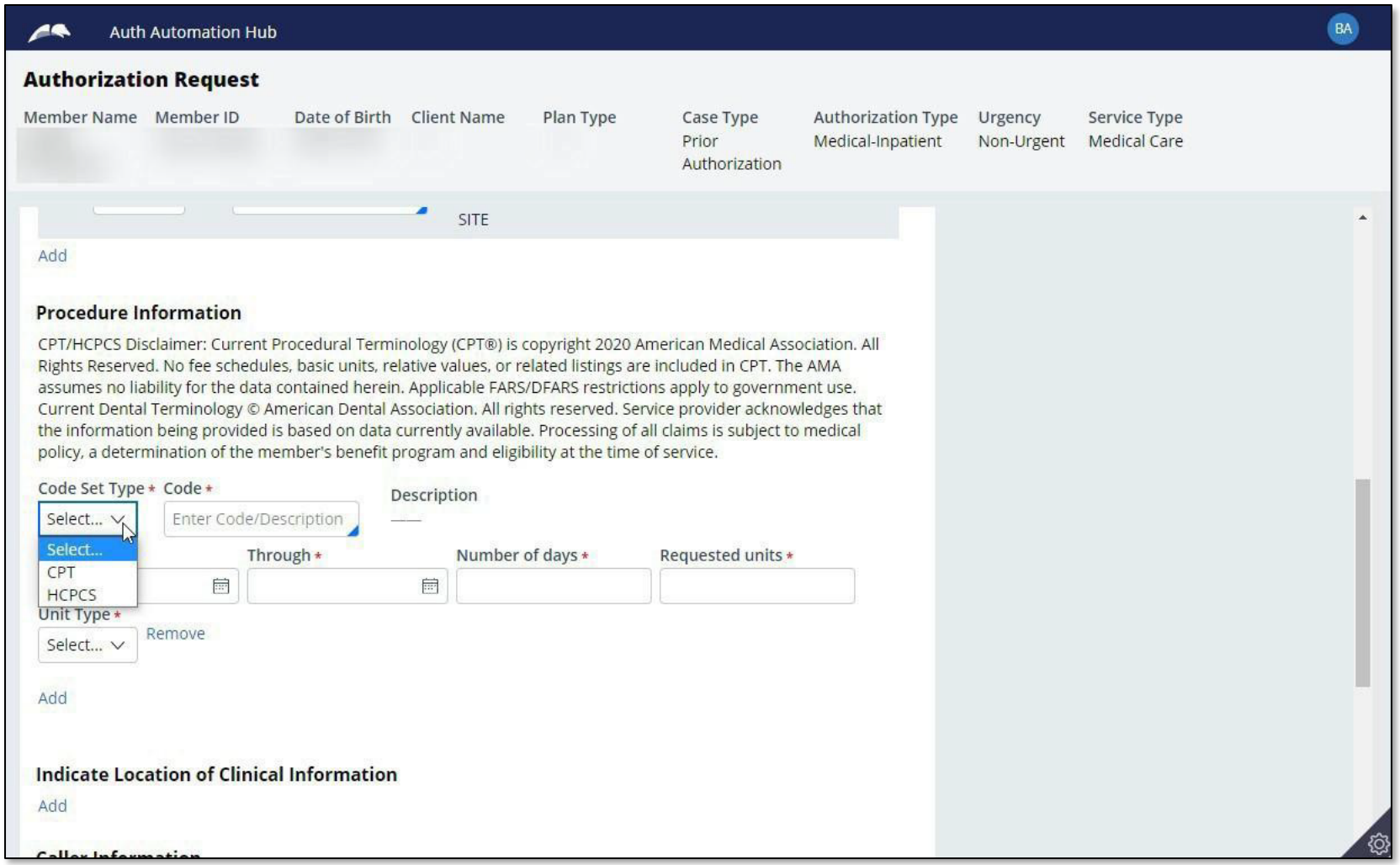
In the **Diagnosis Information** section- entering a partial diagnosis code or description will populate a list of codes for you to select from. You must include the **decimal point** when entering your **diagnosis**.



If you have entered an incorrect code, you can click the **Remove** link to delete that diagnosis from the request. Select the **Add** link to add additional diagnosis codes.



When entering the **Procedure Information** – you **must** select the appropriate **Code Set Type**. If this is not selected, your procedure code will not be found.



Note: A **CPT** Code is a 5-digit numeric code.

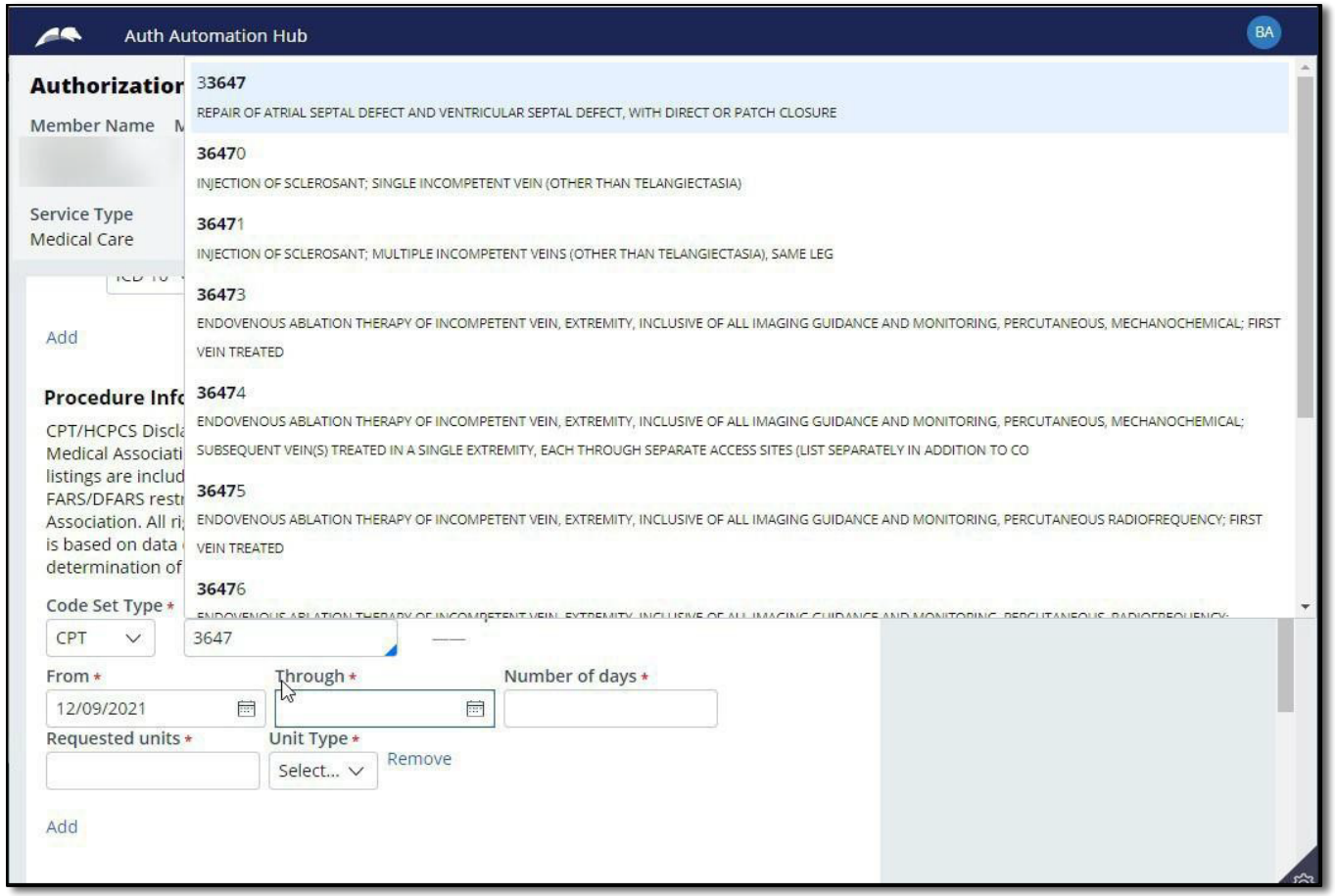
A **HCPCS** is a 5-digit code that begins with an alphanumeric value.

Once you have selected the **Code Set Type**, enter a partial procedure code or description to see a list of codes you can select.

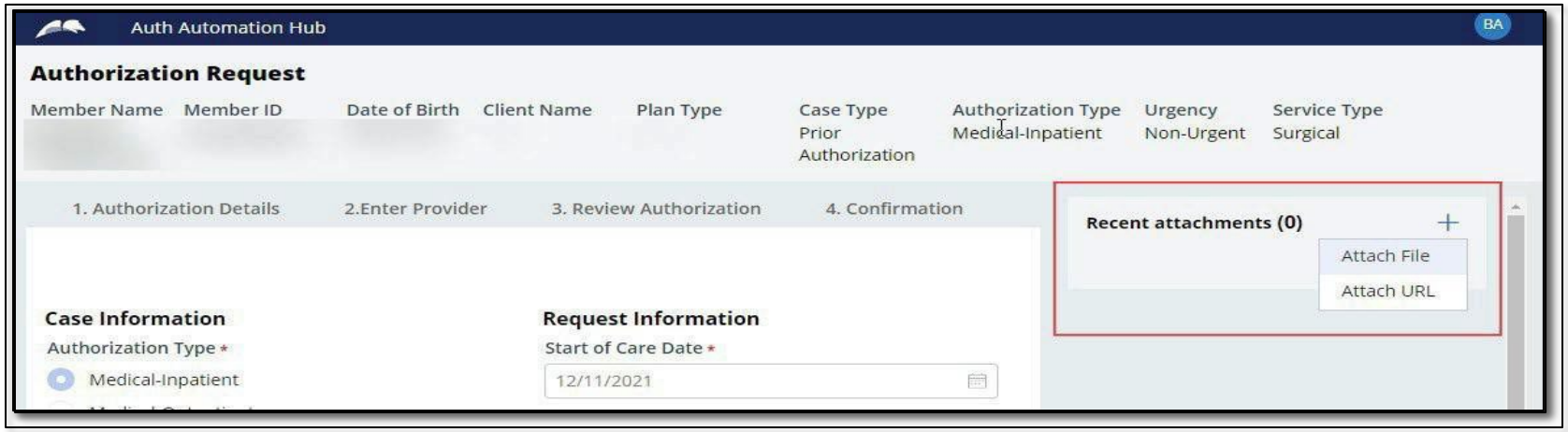
Next, complete the remaining required fields.

Like the **Diagnosis** section, you can select **Remove** if you have entered something incorrectly. Click **Add**, if you need to authorize more than one procedure code.

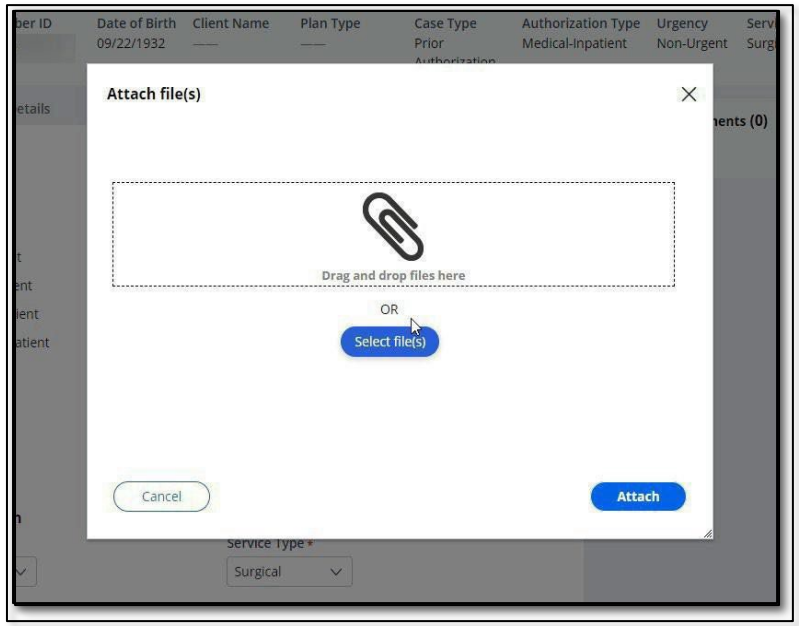
Note: There is no limit to the number of procedure codes that can be added.

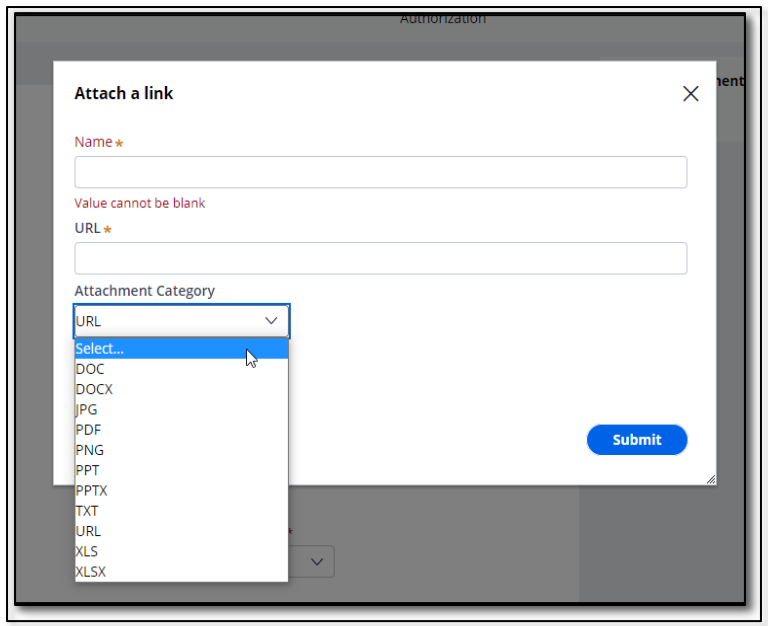


The **Recent Attachments section** will allow you to send attachments with an authorization by clicking on the **+ icon**.

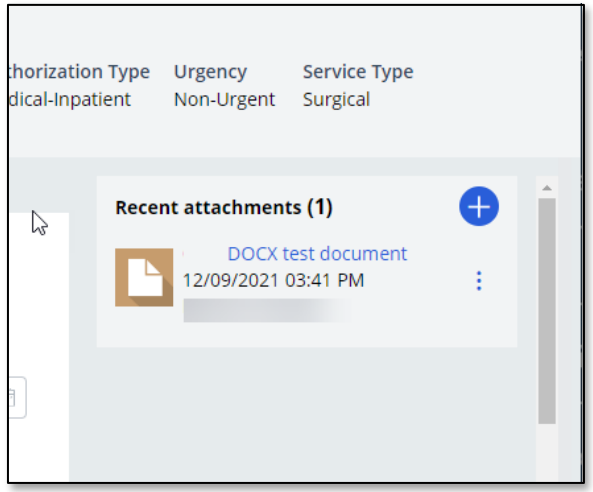


You can also attach a file or a URL in the **Recent Attachments** section.



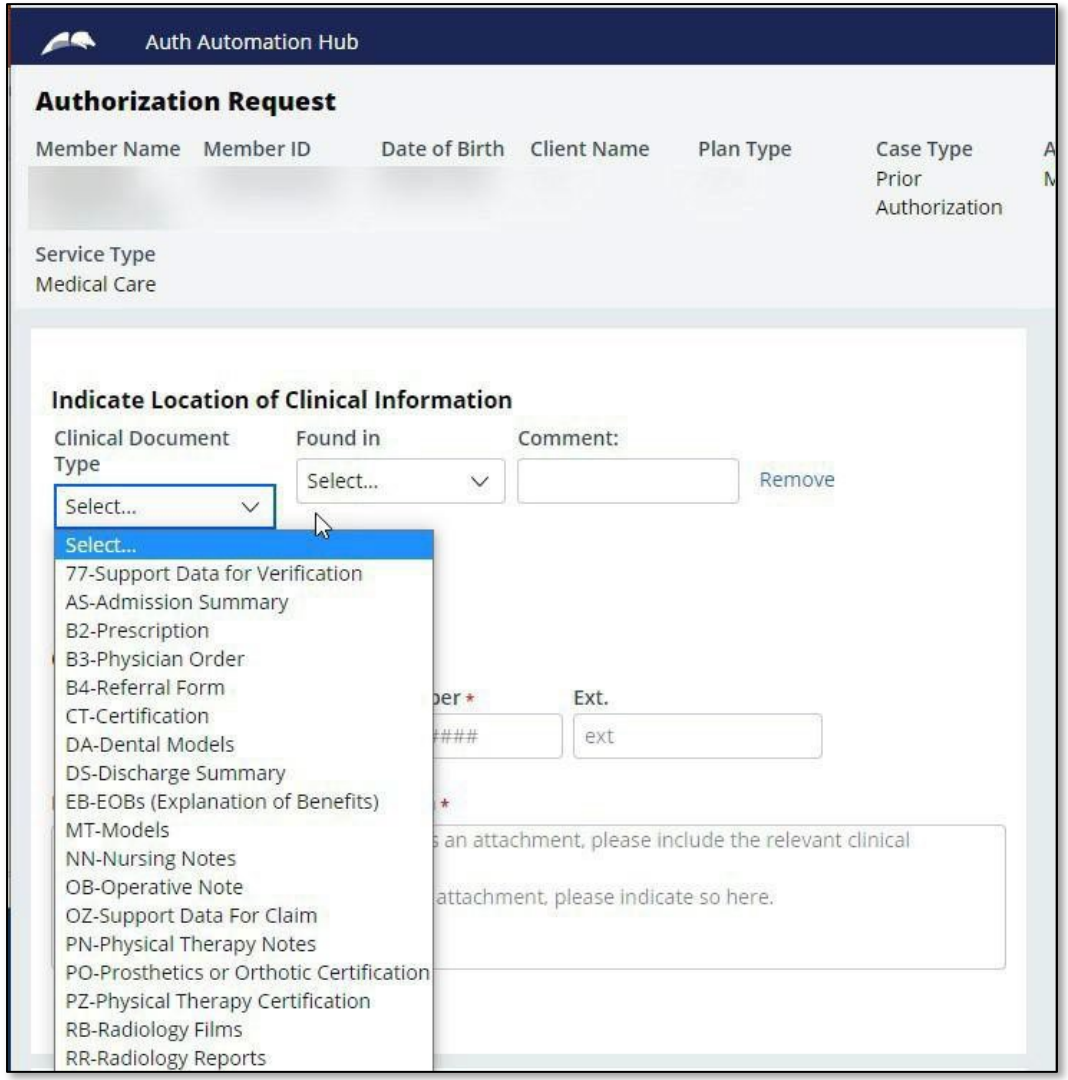


Note: If your authorization is for urgent inpatient admission, you will have the opportunity to utilize MCG criteria later in the workflow. Utilizing MCG criteria and attaching any supporting documentation will greatly reduce response time as well as provide additional clinical to support the inpatient request.



When a document has been attached in the **Recent Attachment** section, you should complete the **Indicate Locations of Clinical Information** section to provide additional informationabout the attachment such as:

- The type of attachment
- Select the attachment being referenced.
- Enter any comments that will assist those reviewing the attachment in finding necessary information.
  - For example – Clinical notes found on page 3 of attachment

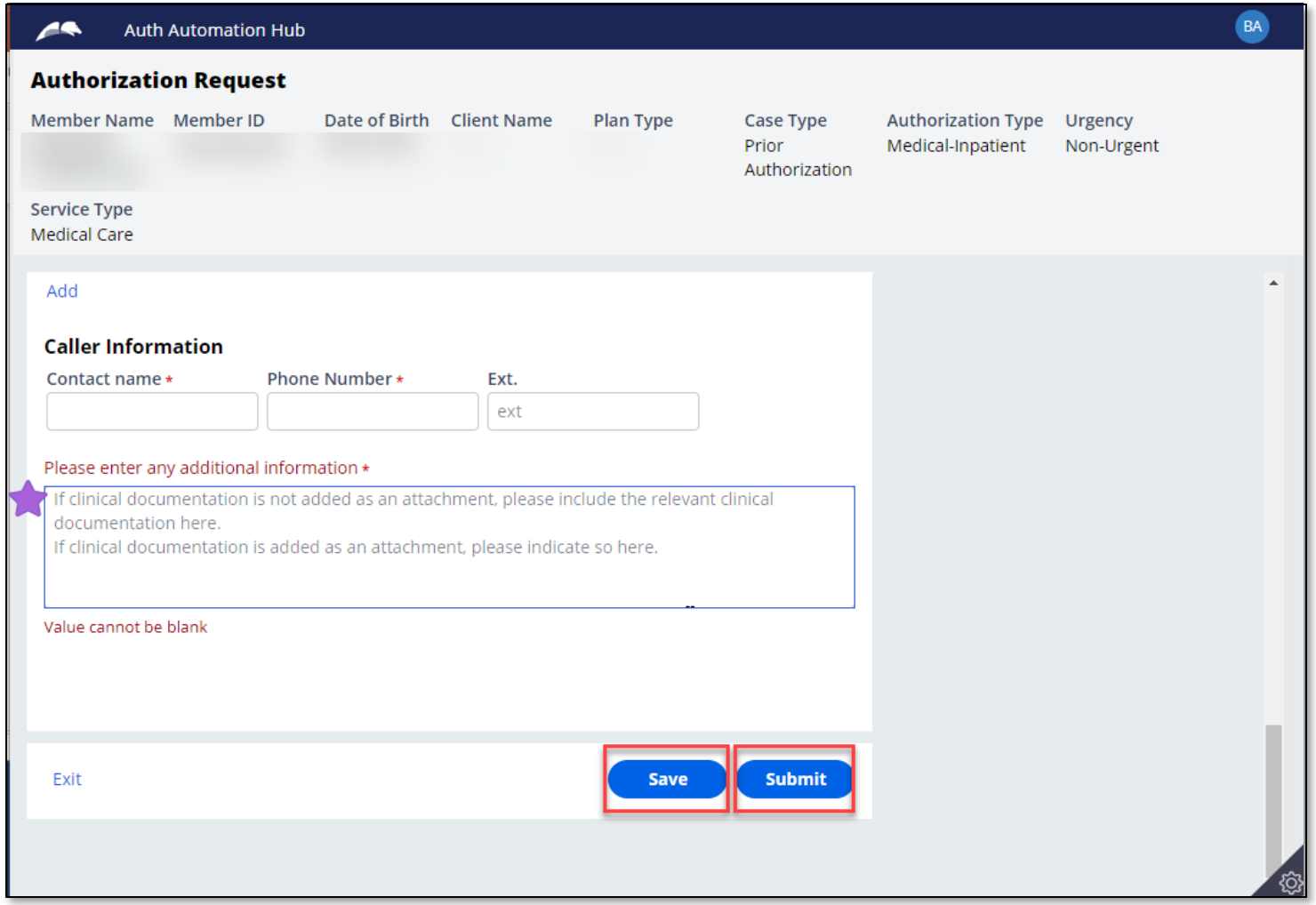


Complete the **Caller Information** sectionby:

- Noting any additional clinical information (there is a 255-character limit)
- If information isn't added in an attachment, include the necessary clinical information here.
- If the clinical information is added as an attachment, please note that here (this is a mandatory field).

NOTE: The phone number field format is (XXX) XXX-XXXX. However, if you enter only the numeric portion it will automatically format.

When all fields are complete, click **Submit**.



The **Provider Details** page will automatically populate with the **Ordering/Attending Practitioner** that was selected previously.

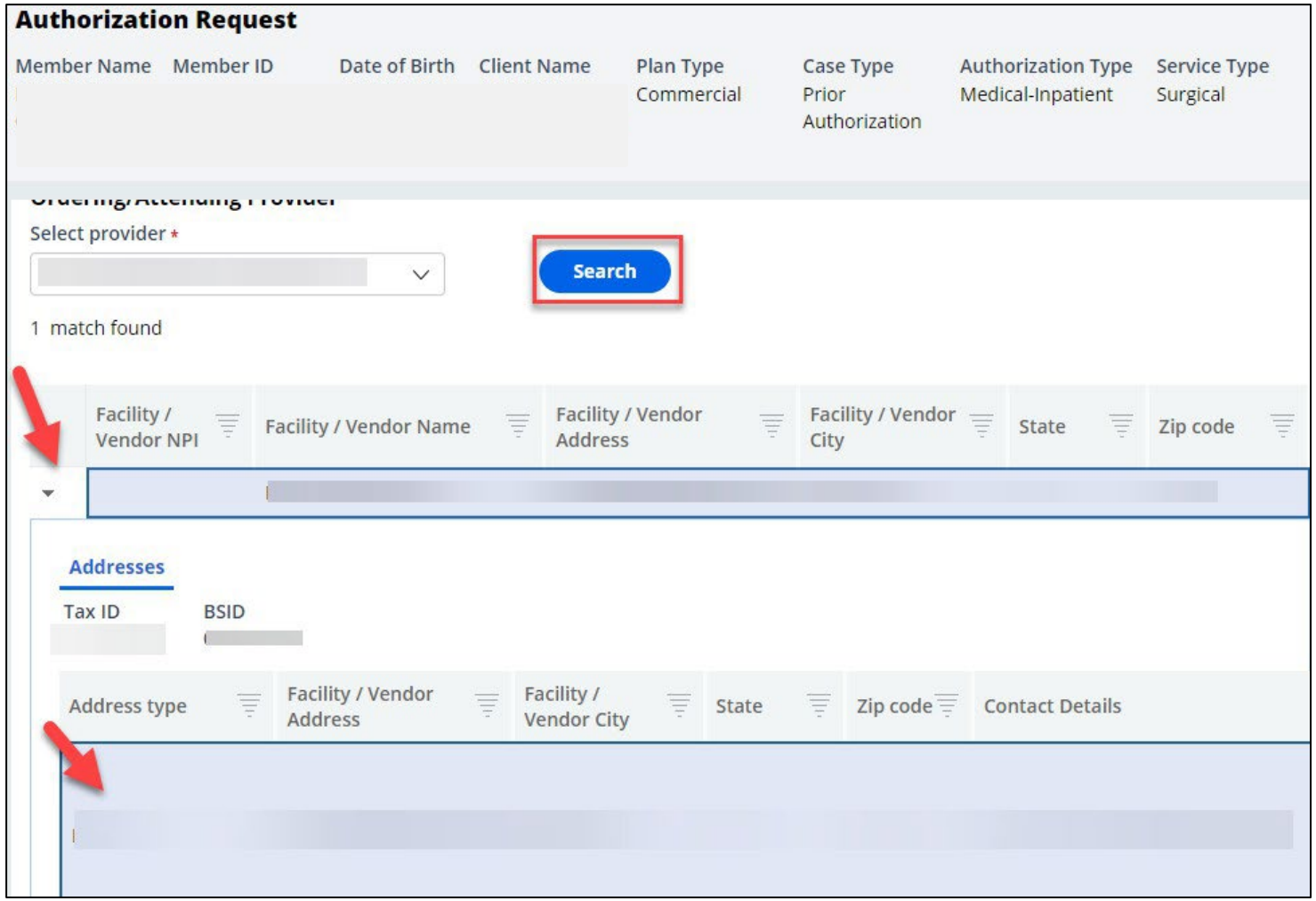
Select **Search** to choose the ordering/attending provider's location.

When results return, to select the appropriate ordering/attending practitioner, you will need to complete the following steps.

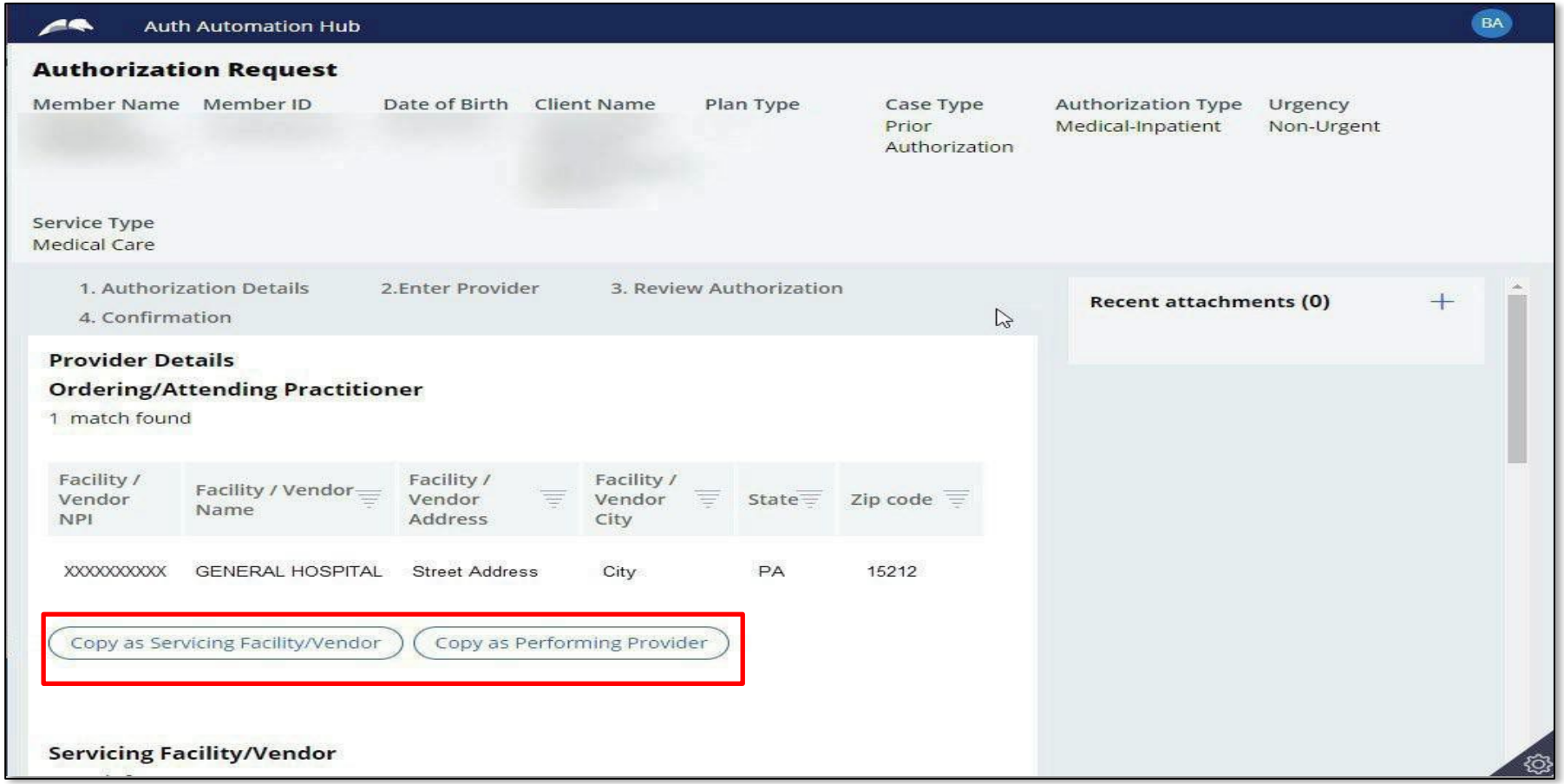
- Click on the **widget** to highlight the **Ordering/Attending Practitioner** and open to view additional information.
- Click on the **address line** to highlight the address

Doing this will select the ordering/attending practitioner that will be submitted with the auth request.

You can then move on to the next field.



Here you will find the **Copy As Servicing Facility/Vendor** and **Copy As Performing Provider** buttons which will allow you to copy the **Ordering/Attending Practitioner** information into the **Servicing Facility/Vendor** and **Performing Provider** information.

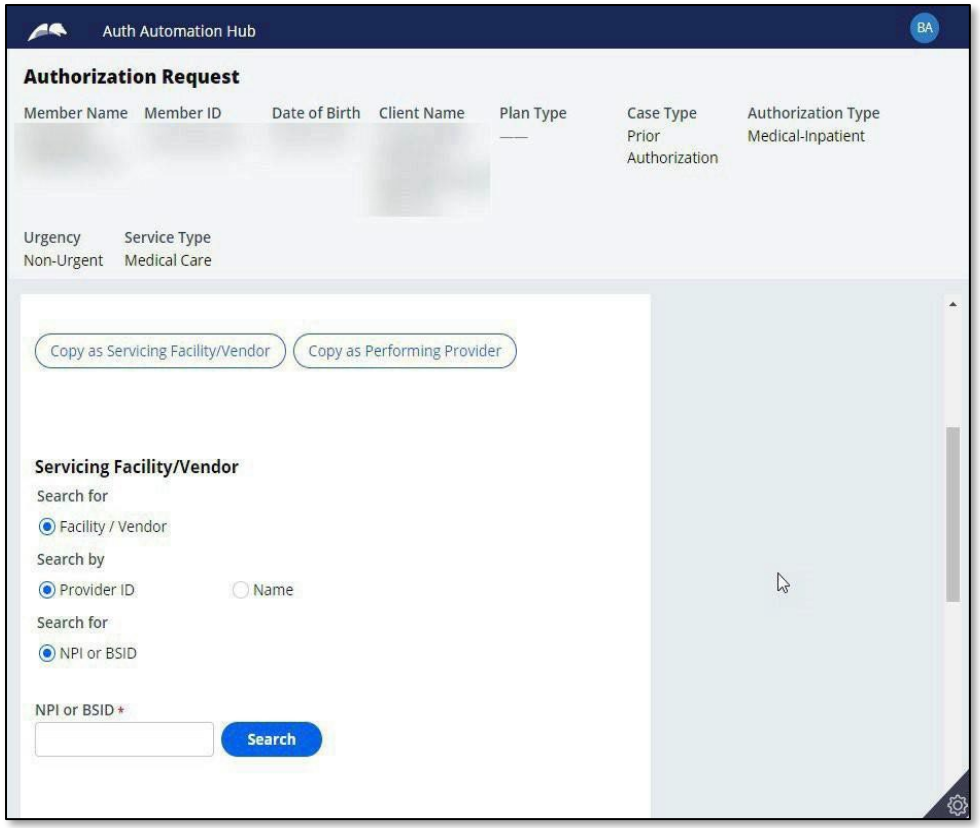


3. Enter Provider

If you do not use the copy links, you can:

Searchforthe **ServicingFacility/Vendor** by the following mandatory fields:

- Provider ID (using NPI or Blue Shield ID)
- Name (Facility/Vendor)

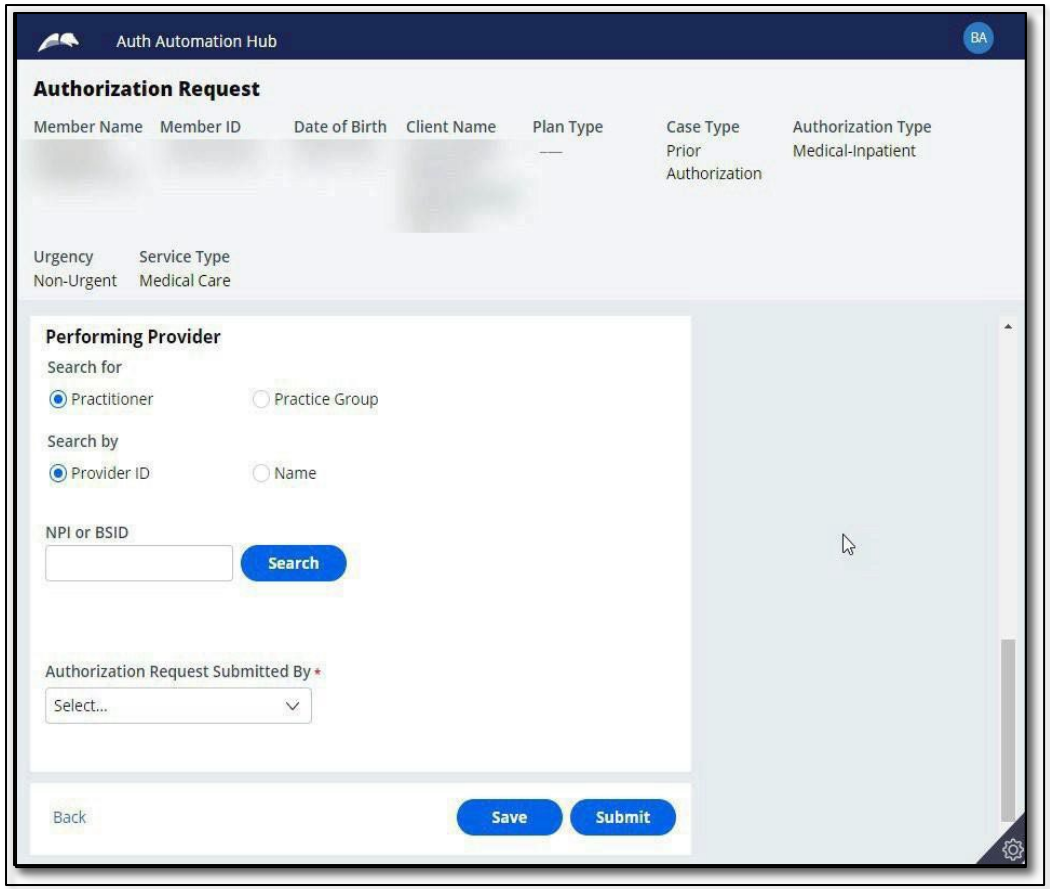


Search for the **Performing Provider** by:
Practitioner using:

- Provider ID (using NPI or BlueShield ID)
- Name

(or) Practice Group using:

- Provider ID (using NPI, Blue Shield IDor Tax ID)
- Name



3. Enter Provider

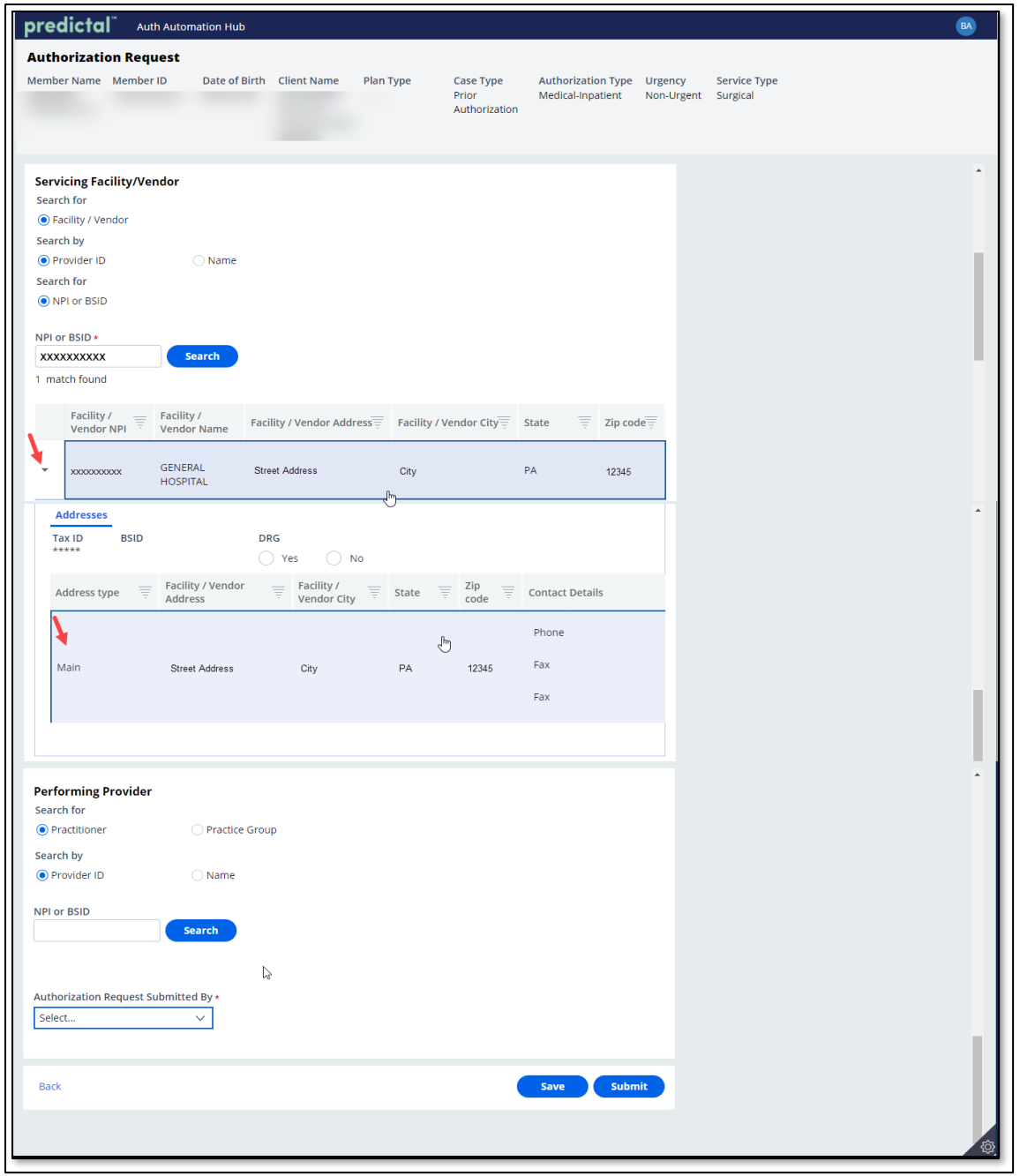
When results return, to select the appropriate facility/vendor, you will need to complete the following steps to select the specific facility/vendor.

- Click on the **widget** to highlight the **facility/vendor** and open the **additional information** about the facility/vendor.

- Click on the **address line** to highlight the address

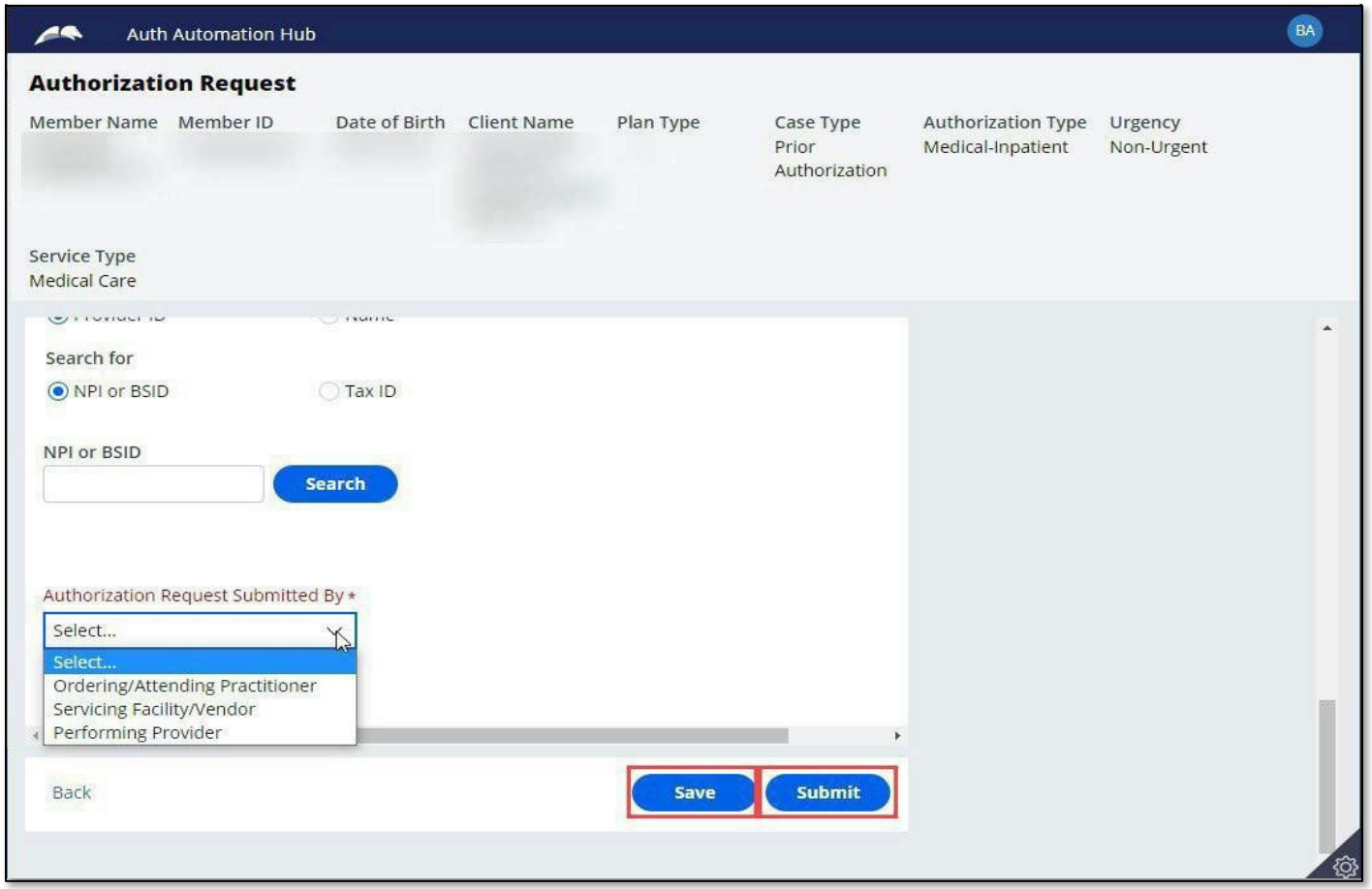
Doing this will select the facility/vendor that will be submitted with the auth request.

You can then move on to the next field.

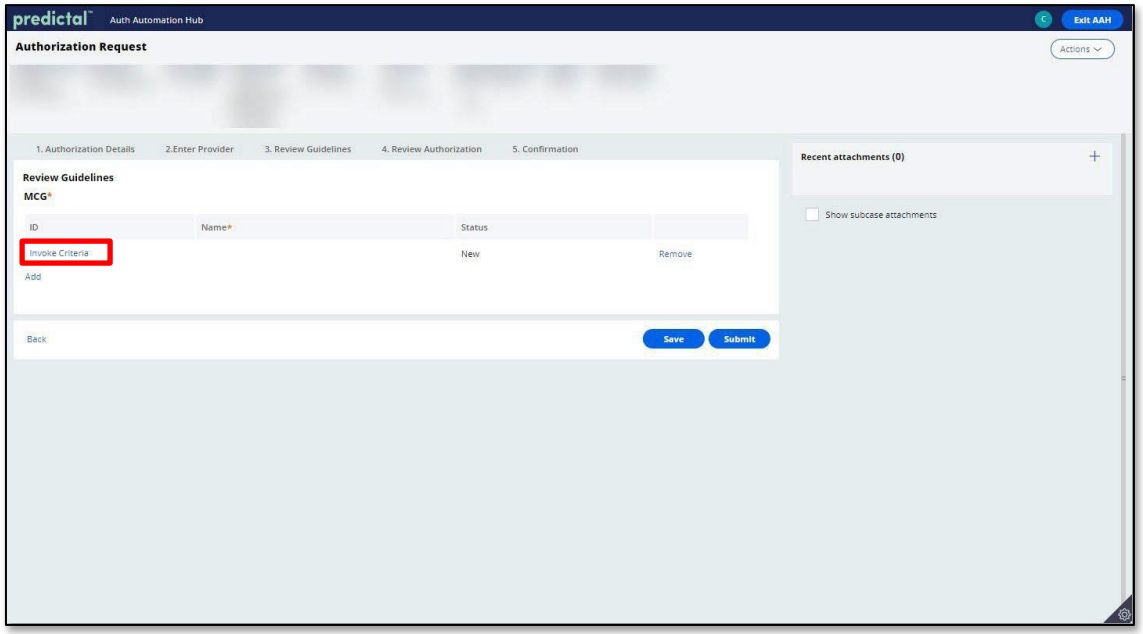


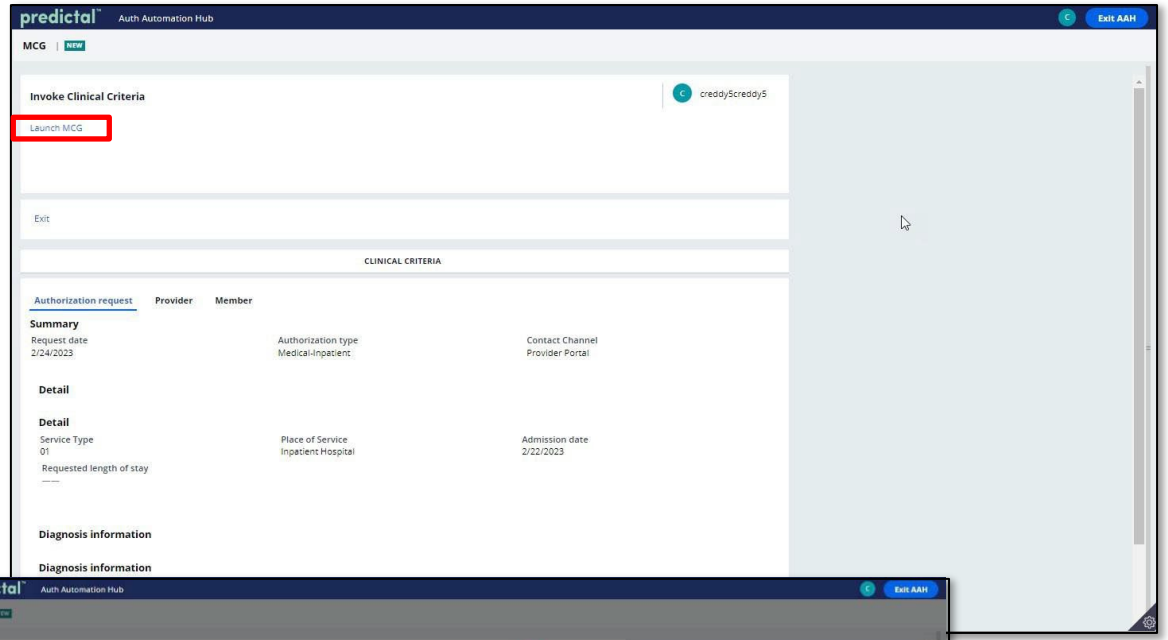
Select the provider who is requesting the authorization in the **Authorization Request Submitted By** drop down.

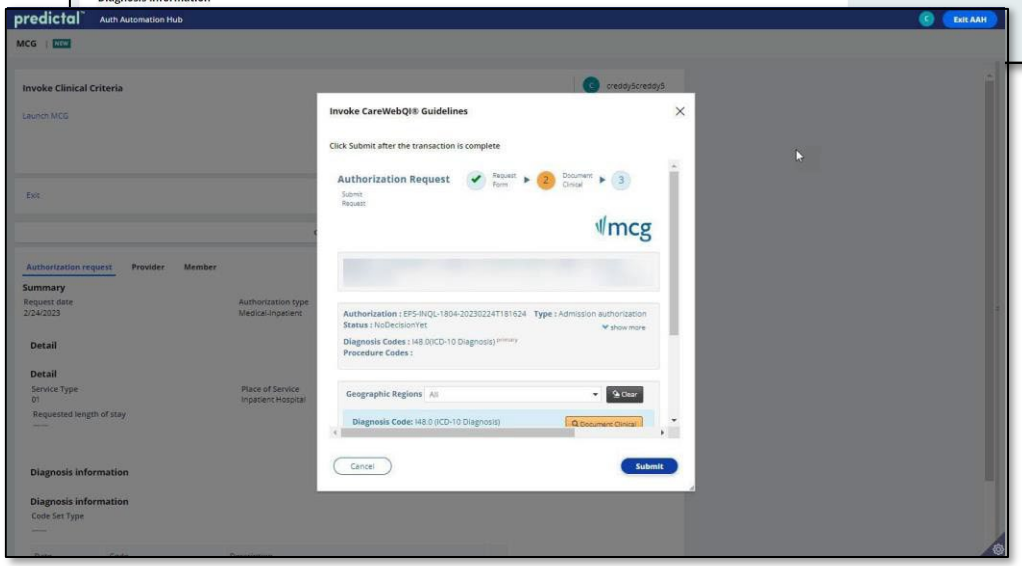
Click **Submit** when all information has been completed.



Inpatient Urgent authorization submissions will require additional clinical criteria. To add the criteria, select **Invoke Criteria**, then **Launch MCG**.





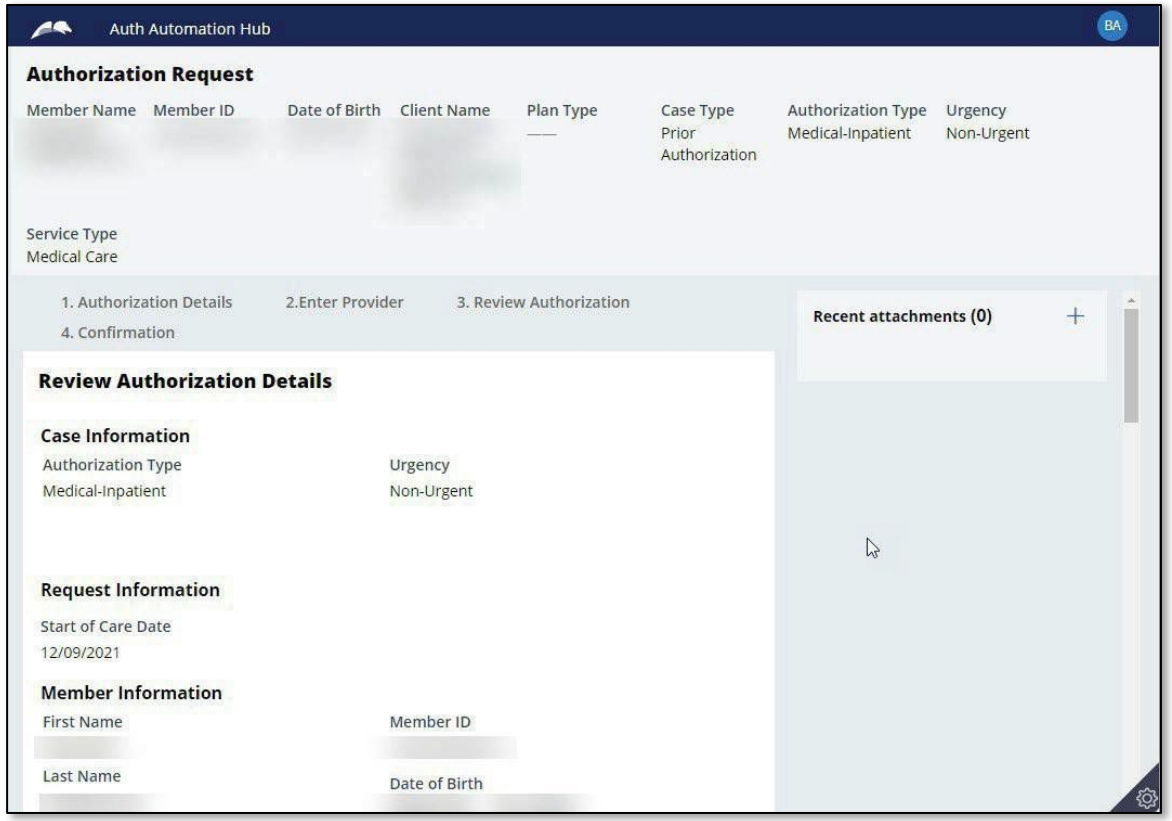


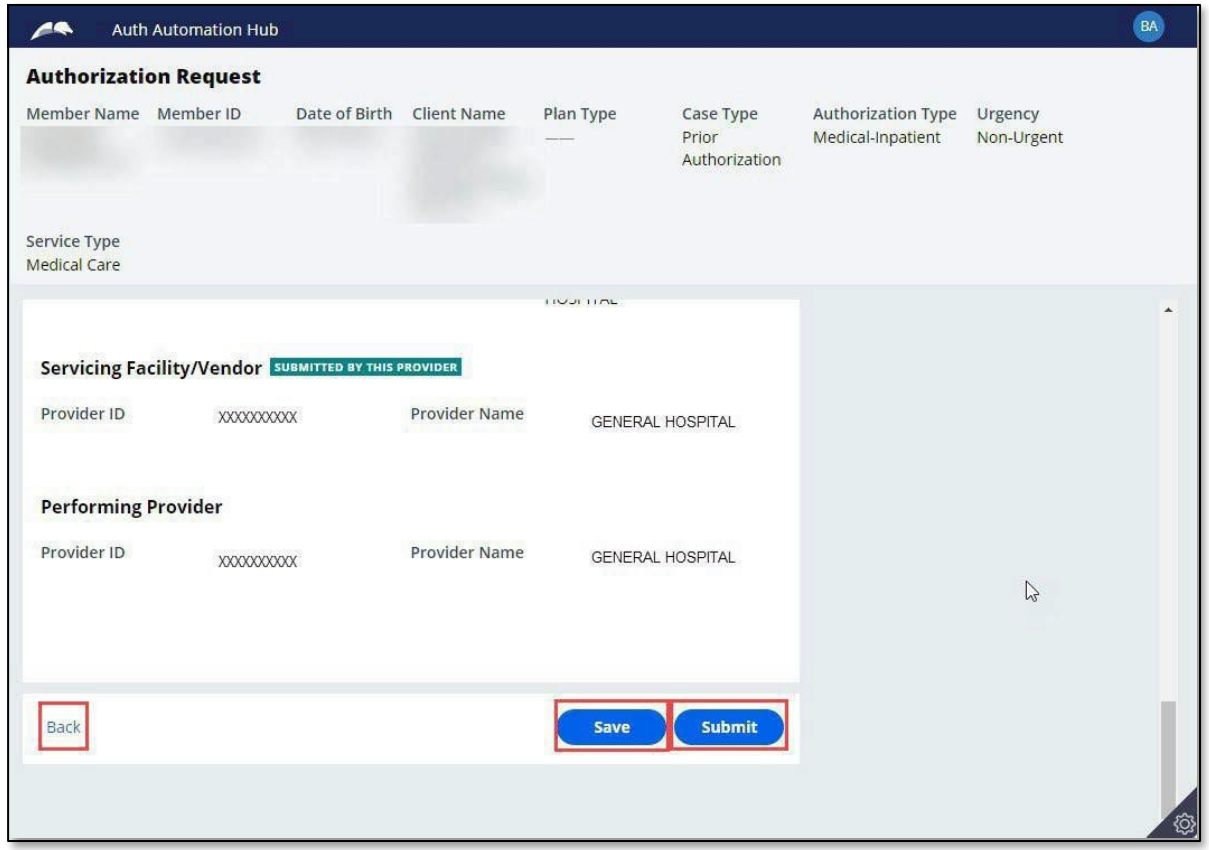
Complete the MCG Criteria by saving before submitting.

4. Review Authorization

After submitting the **Provider Details**, users will be taken to the **Review Authorization Details** page to review all information submitted to this point.

Scrolling to the bottom will allow users to **Submit.** This is the **final submission** which will send your authorization request for review.

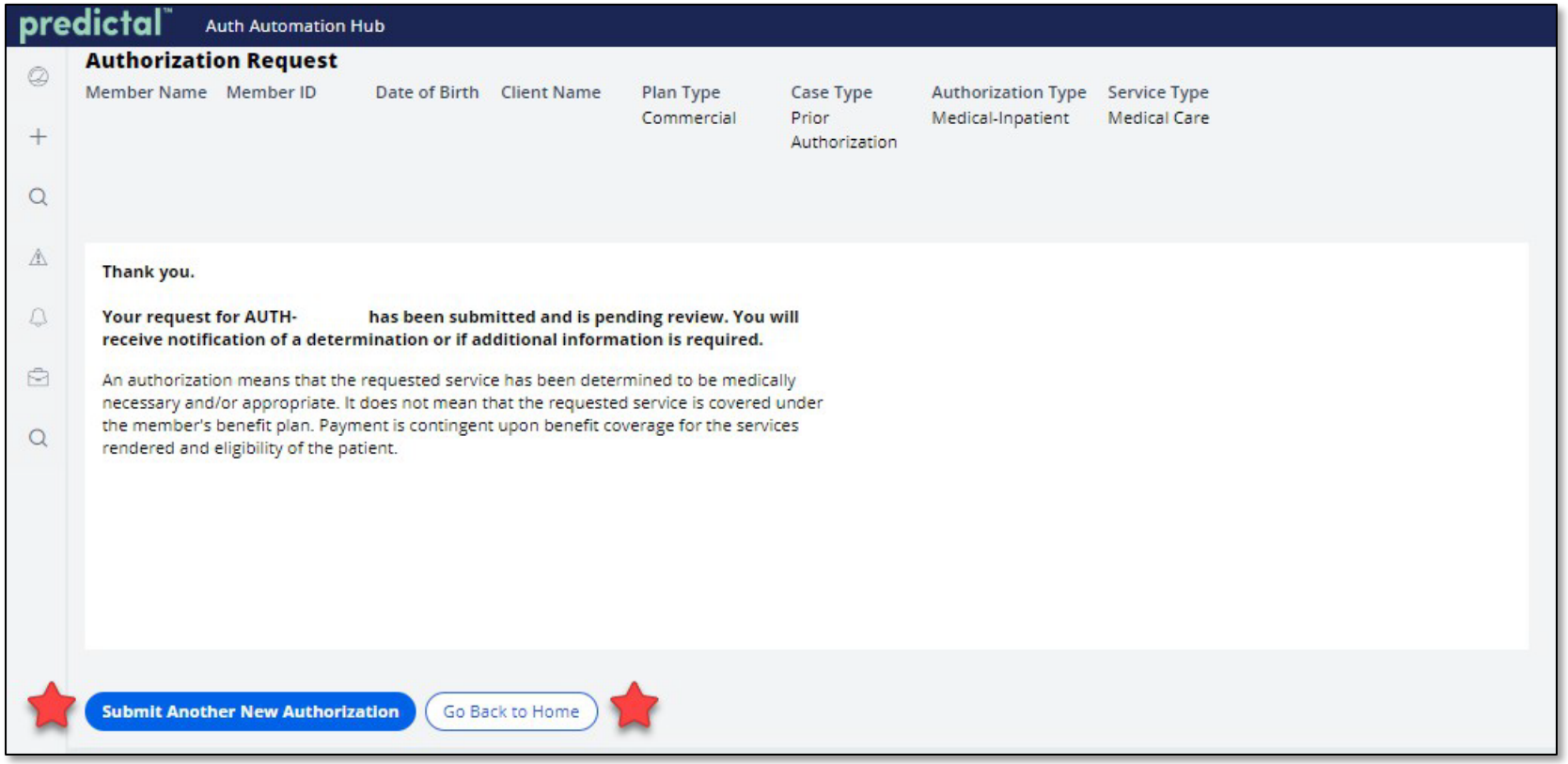




5. Confirmation

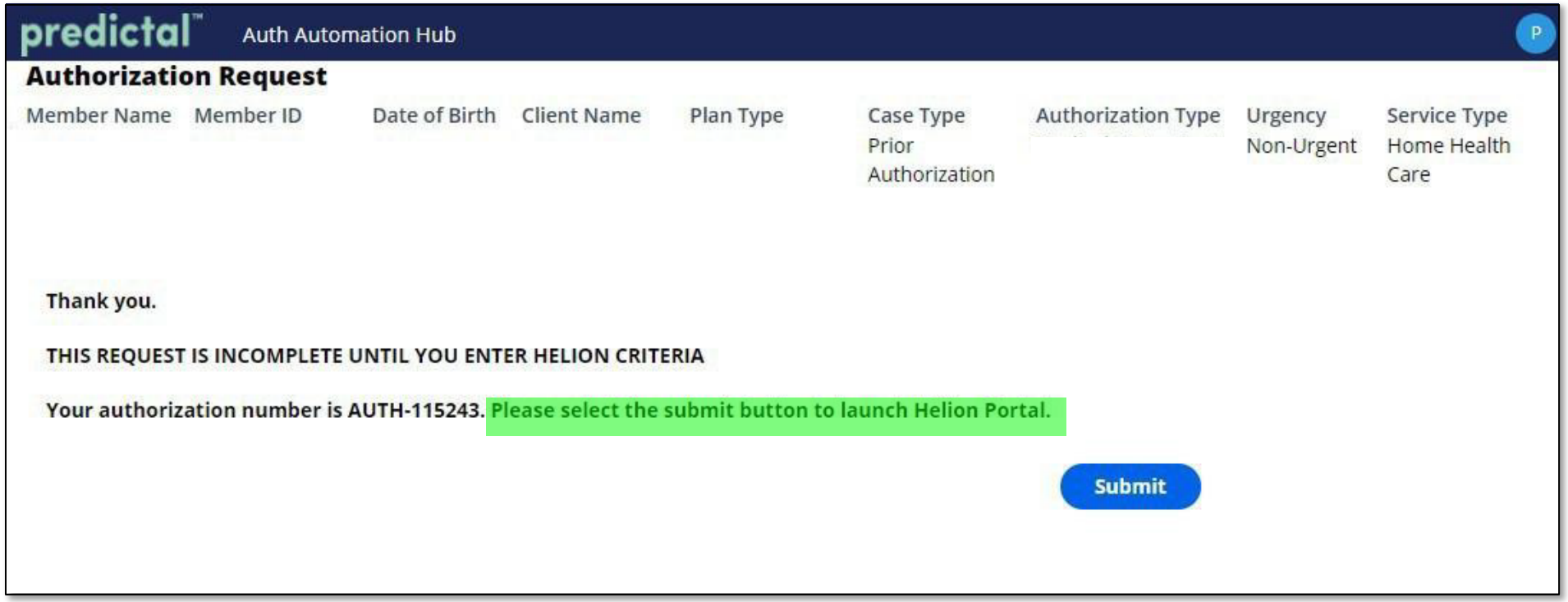
When the authorization is submitted, a confirmation will be displayed on the page with the **Authorization Number**.

From here, you can select to submit another **Authorization Request**, or return to the Predictal home screen.



Please note: When submitting Inpatient Transfer – Skilled Nursing Facility, Acute Rehab or Long-Term Acute Care requests, be sure to click **Submit** to launch to the Helion Portal.

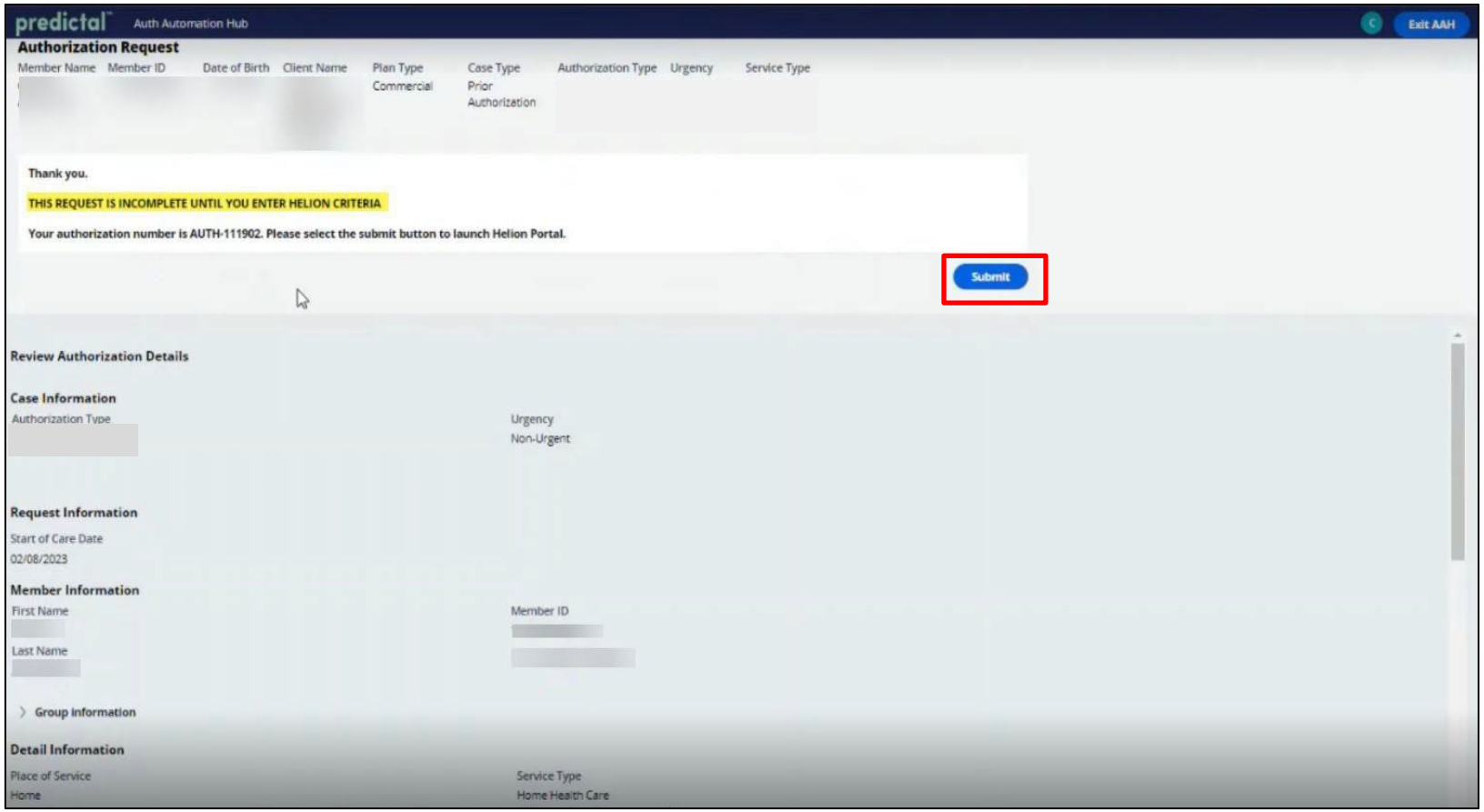
Additional information Helion Arc begins on the next page of this guide.



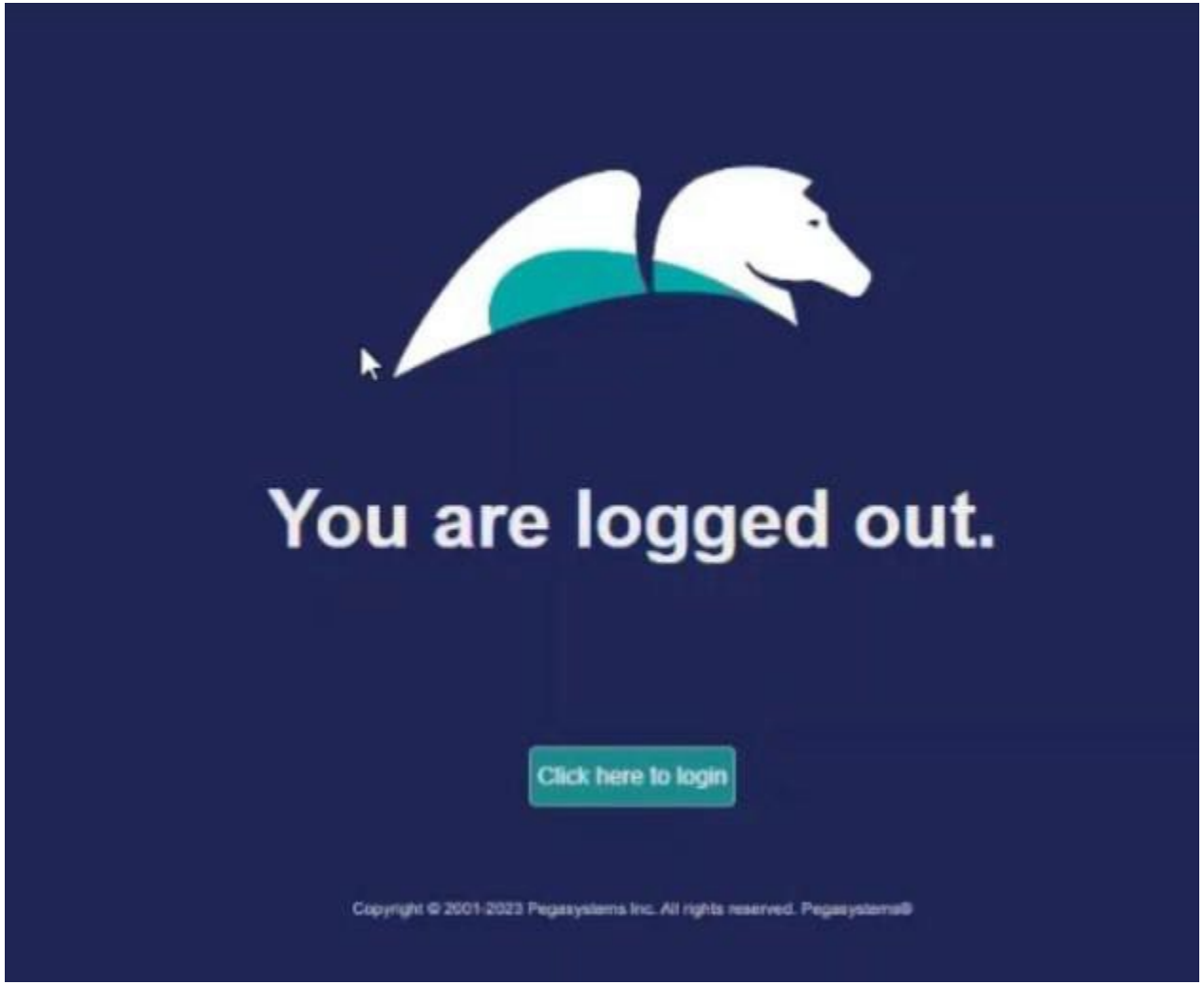
Helion Arc Authorization Submission

If you are submitting a request for an Inpatient Transfer – Skilled Nursing Facility, Acute Rehab or Long-Term Acute Care - You will get a notification that the request is incomplete until Helion criteria is entered.

Hit **Submit**.



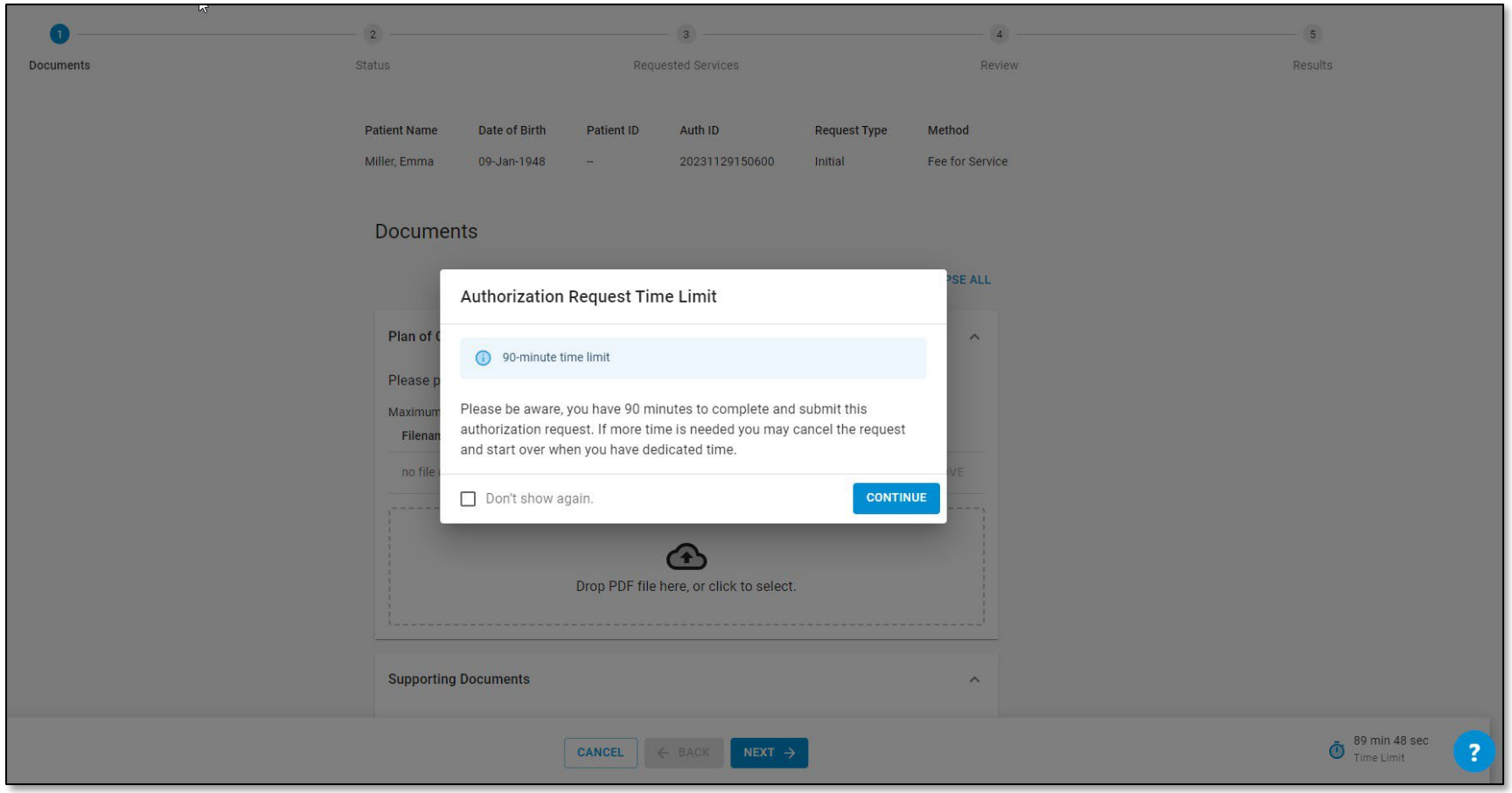
You will be automatically logged out of the Predictal Auth Automation Hub and taken directly to Helion Arc.



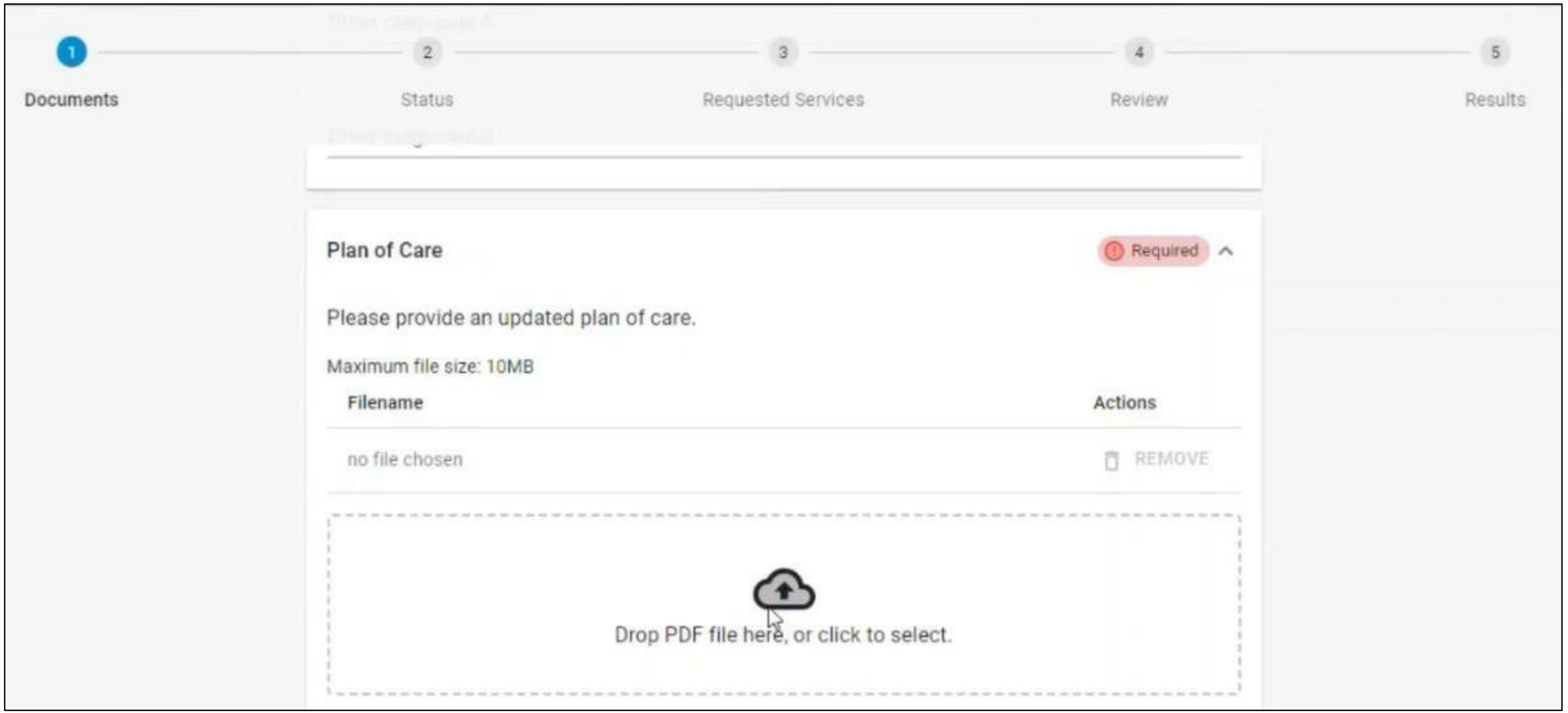
Once in Helion Arc, you will receive a message regarding the **Authorization Request Time Limit**, which indicates you have 90 minutes to complete and submit the authorization.

Click **Continue**.

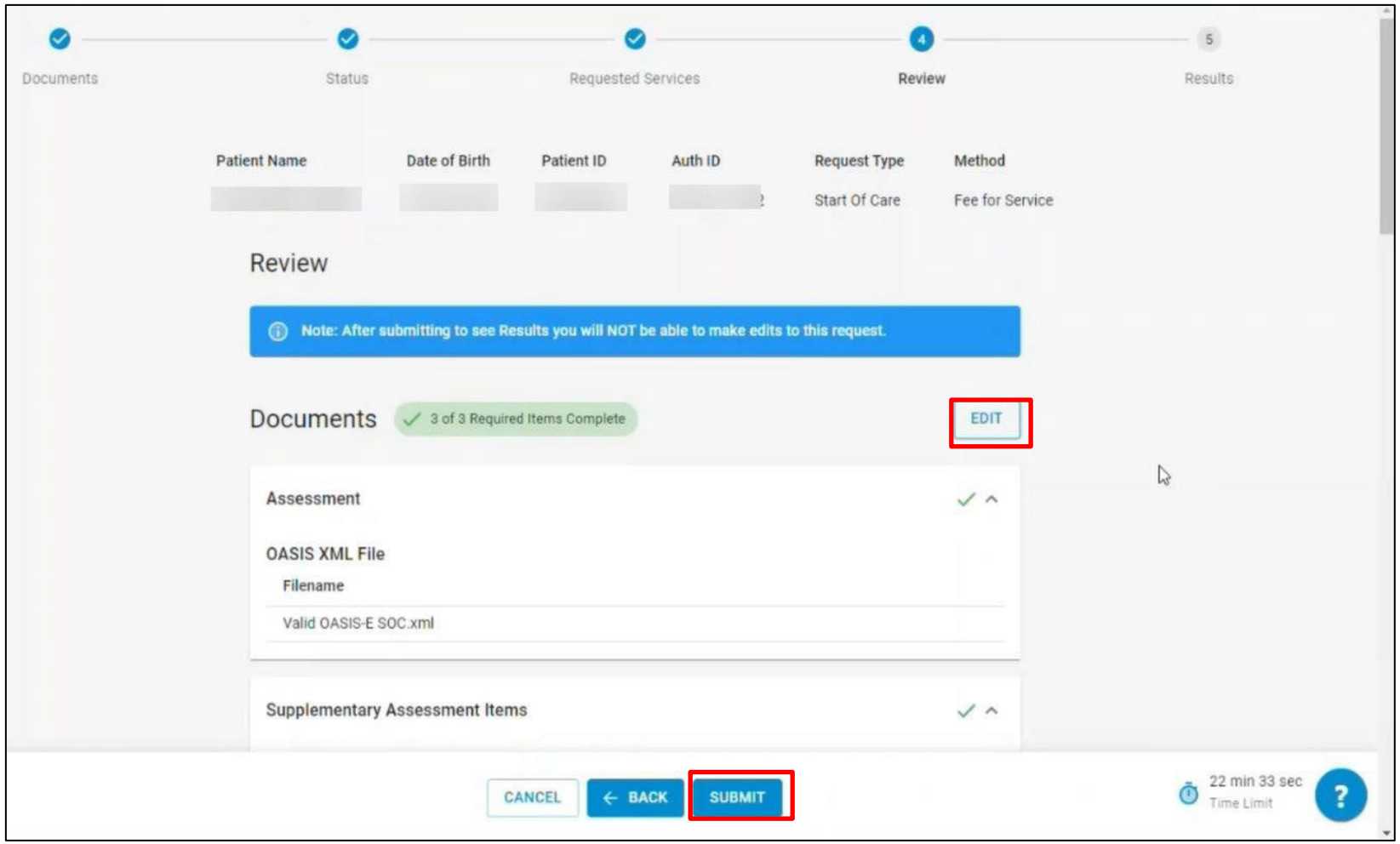
(Content may differ between requested services)



Youcan upload your **Plan of Care**. This can be uploaded as a PDF file.



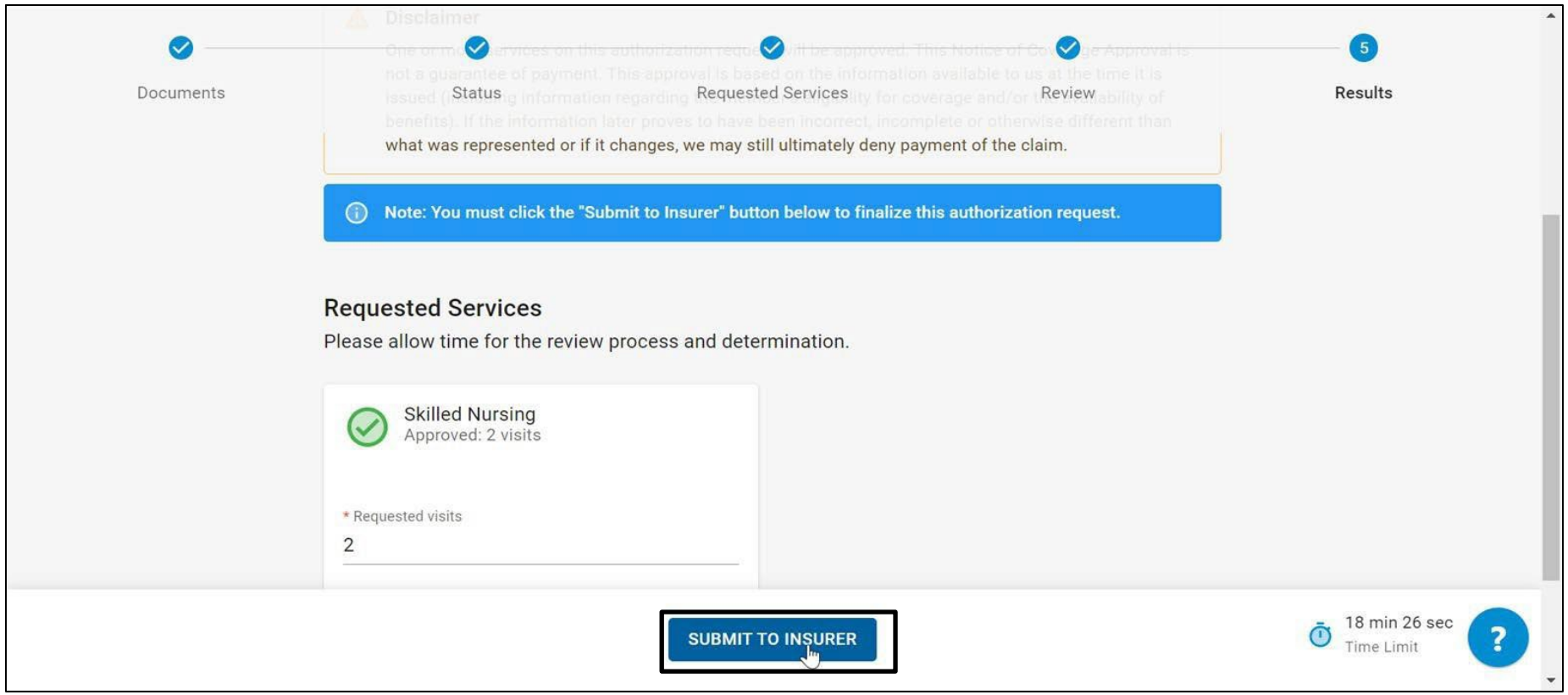
This is a review screen. You can edit any information using the **Edit** button located in each section. If all information looks correct, hit **Submit.**



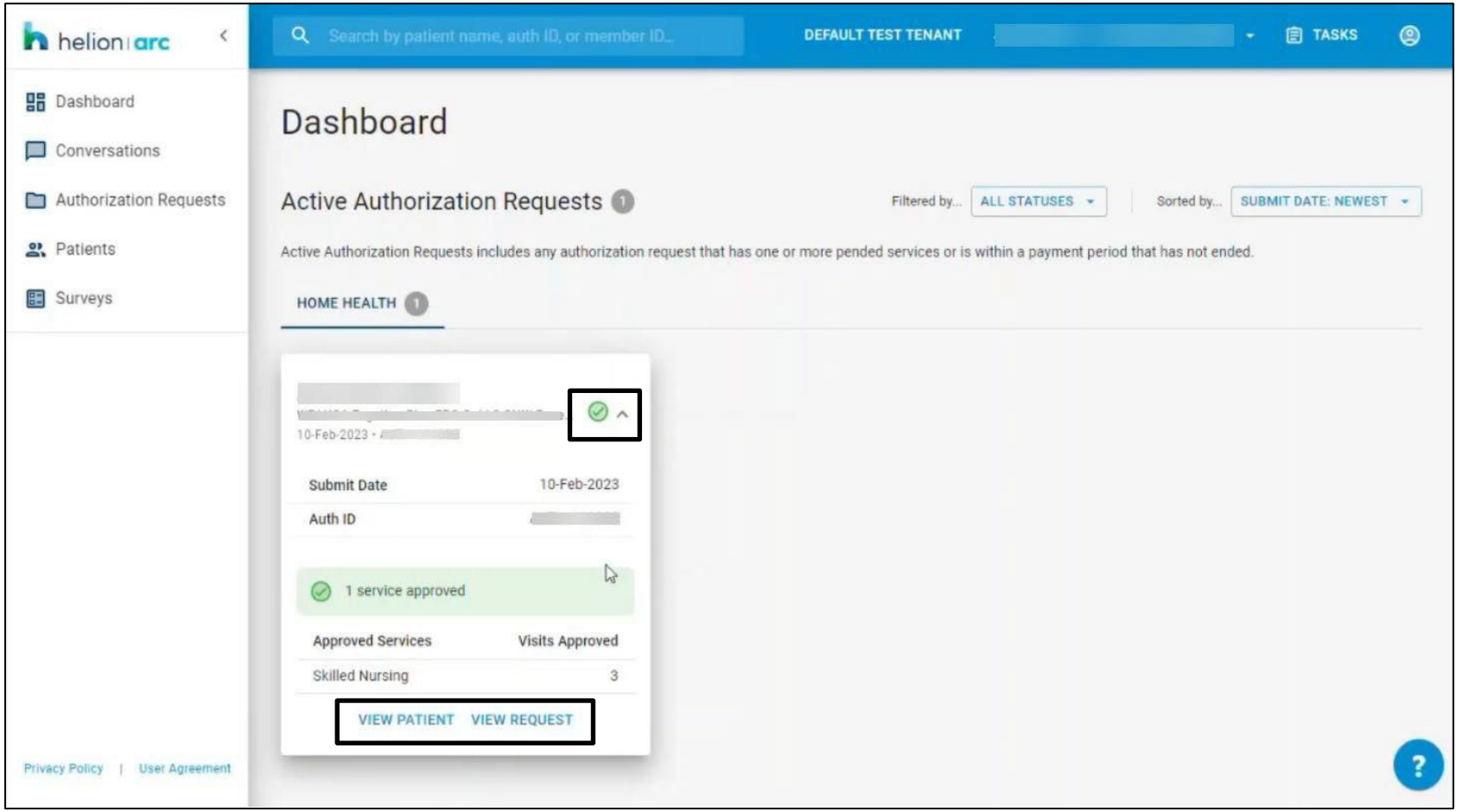
The request will be “Approved” or “Pended.”

If the authorization does **not** meet medical necessity through Helion Arc, it will be pended to a clinician at the Health Plan for review. You will be notified of the final determination via the provider portal.

Click “Submit to Insurer.”

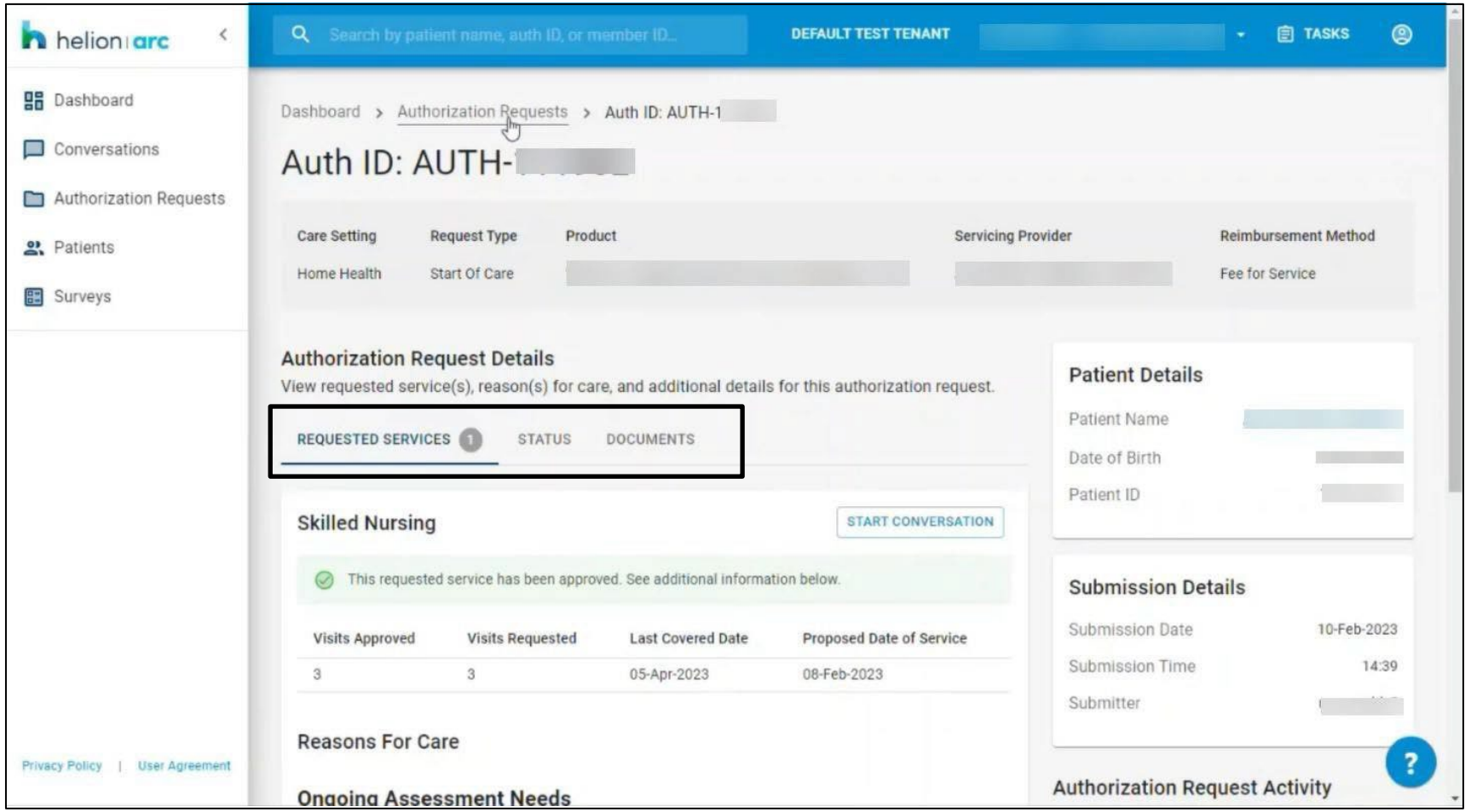


You will be directed to the Helion Arc dashboard, where you can view all active authorization requests. Clicking the arrow will open the patient and request information.

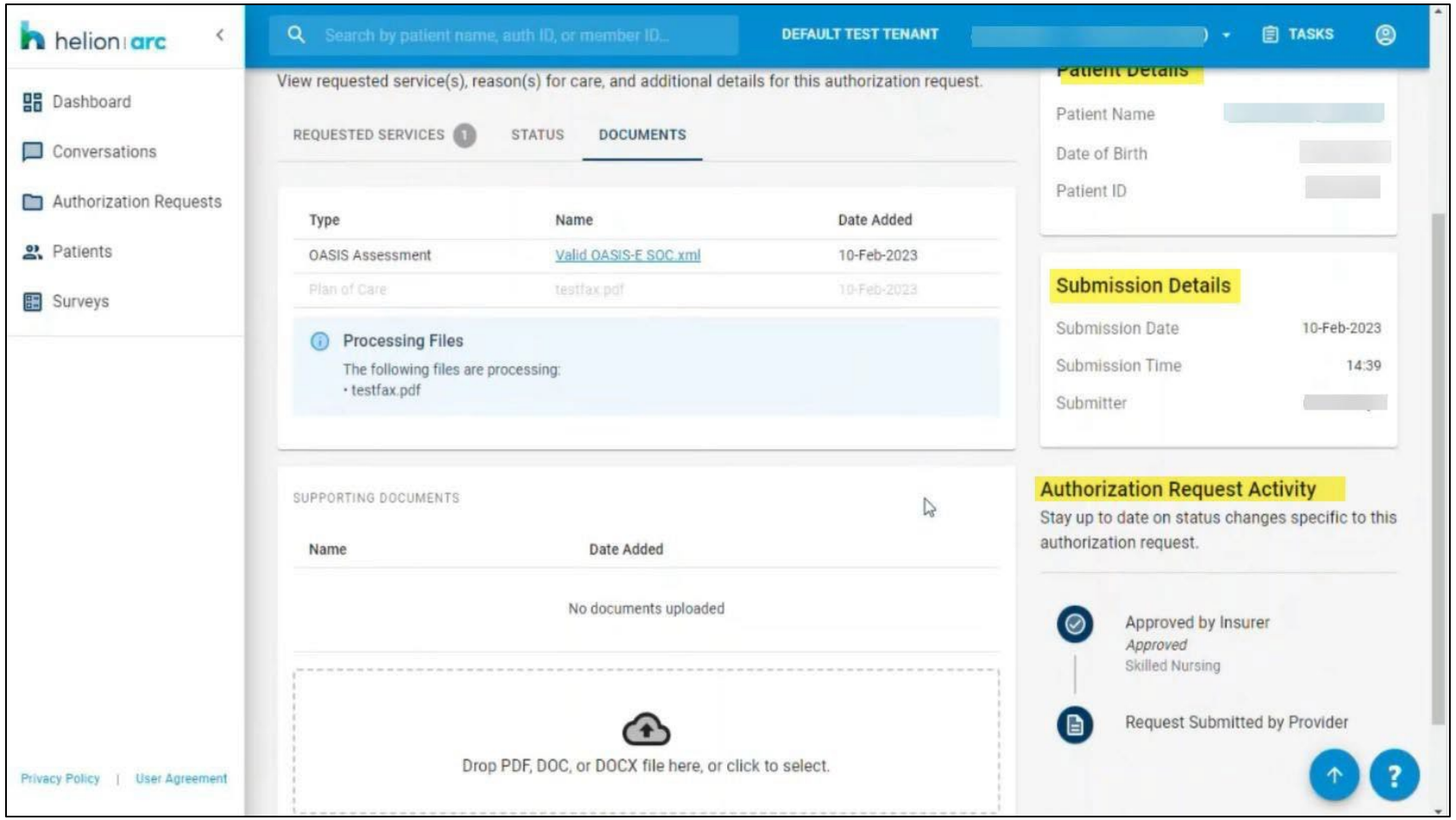


Clicking on either **View Patient** or **View Request** will open the **Authorization Request Details**.

You can see the Auth number at the top, as well the Requested Services, Status, and any Documentation that has been uploaded.

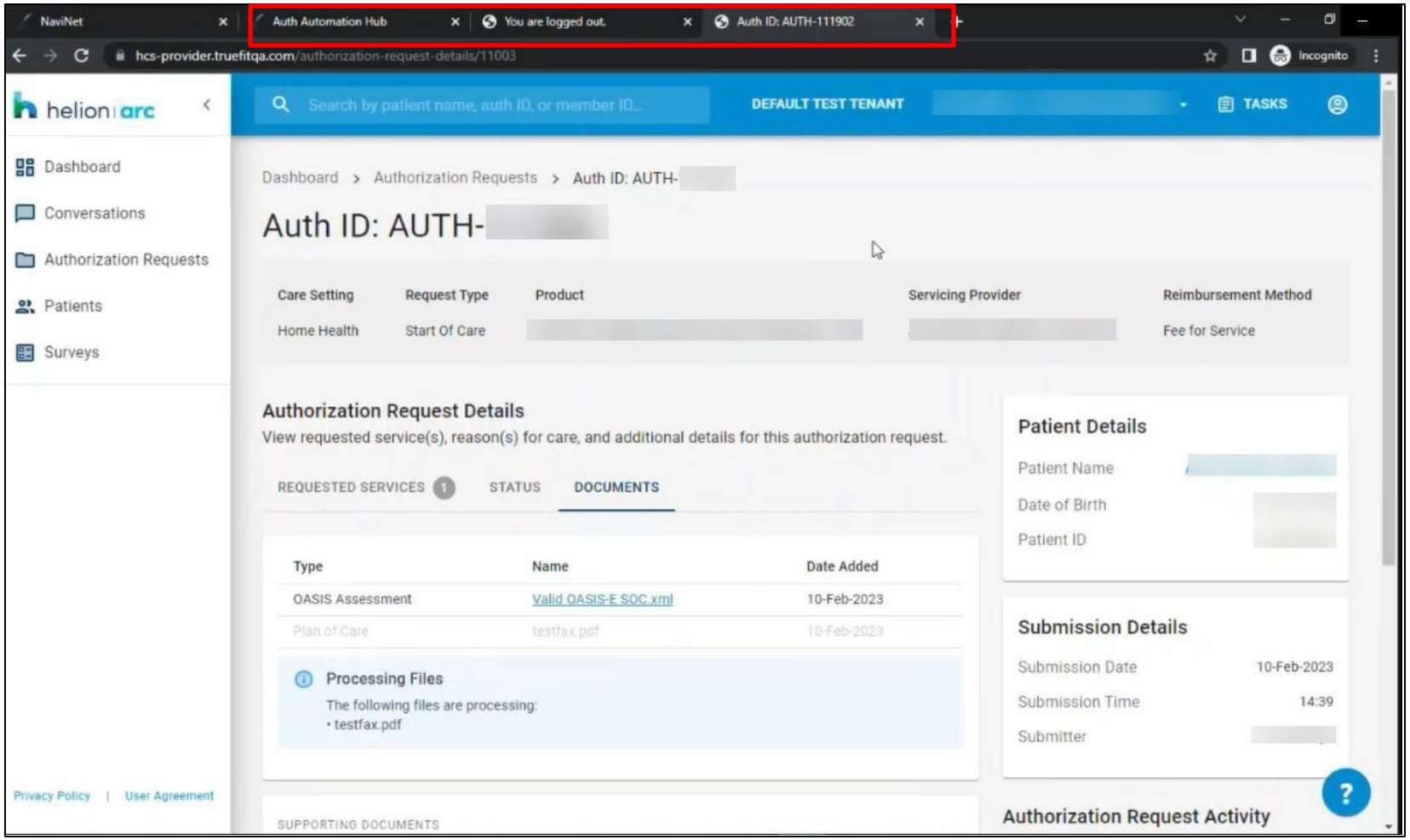


The panels on the right-hand side of the screen show you Patient Details, Submission Details, and an audit history under ‘Authorization Request Activity.’



This completes the submission process for a request through Helion Arc.

You can now close out of any browser tabs as needed using the ‘X’ on each tab.



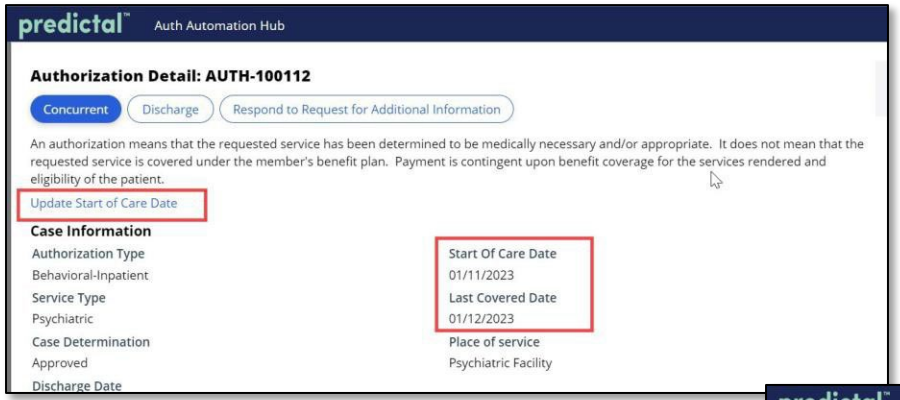
Availity Provider Portal - Predictal Authorization Inquiry

Change/Update Start of Care Date

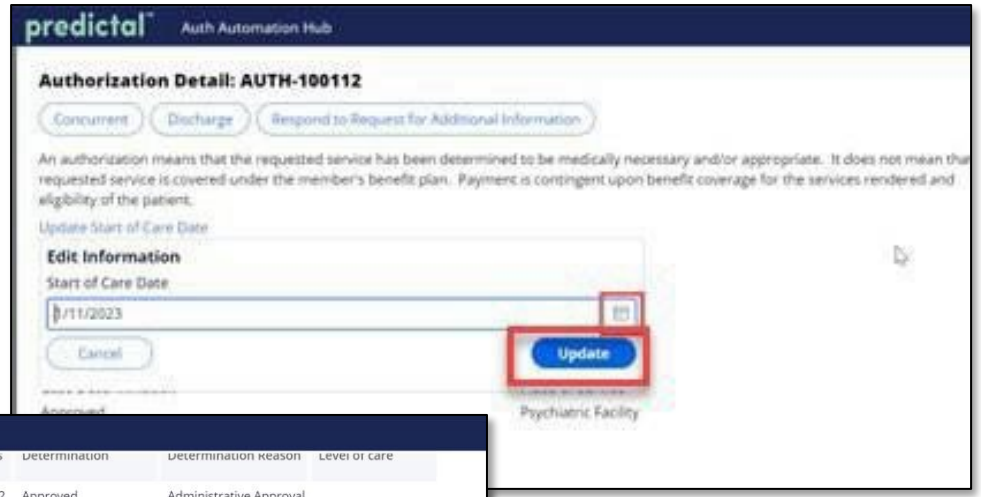
To update the Start of Care Date after the authorization is submitted:

1. Go to **Auth Inquiry**
2. Click the **Update Start of Care Date** hyperlink.
3. Click the calendar in the **Edit Information** field, select the appropriate Start of Care Date, and click **UPDATE**.
   IMPORTANT: This date must be within 7 days prior to the original Start of Care Date that was selected or within 30 days in the future of the original Start of Care Date.
4. **Save** your changes.

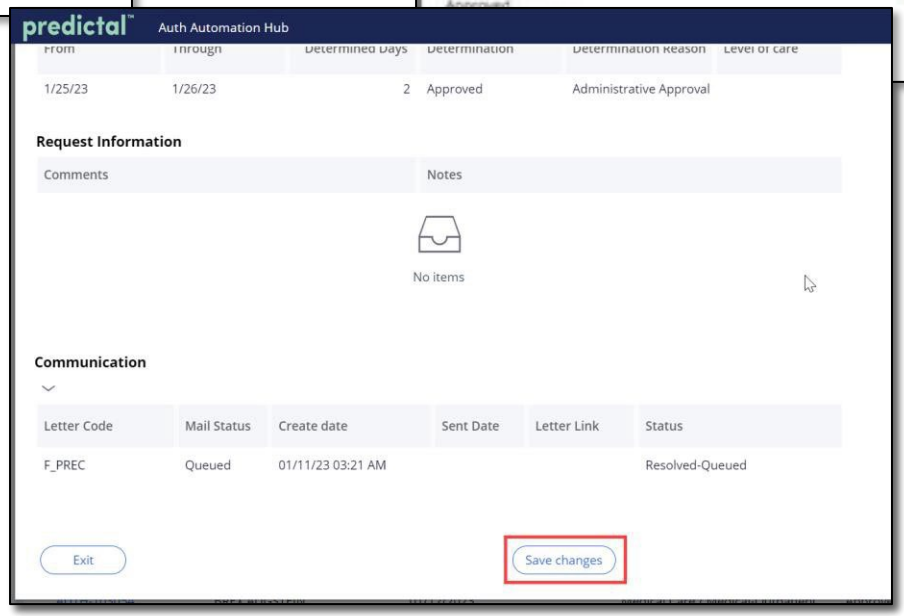
Step 1



Step 2



Step 3



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