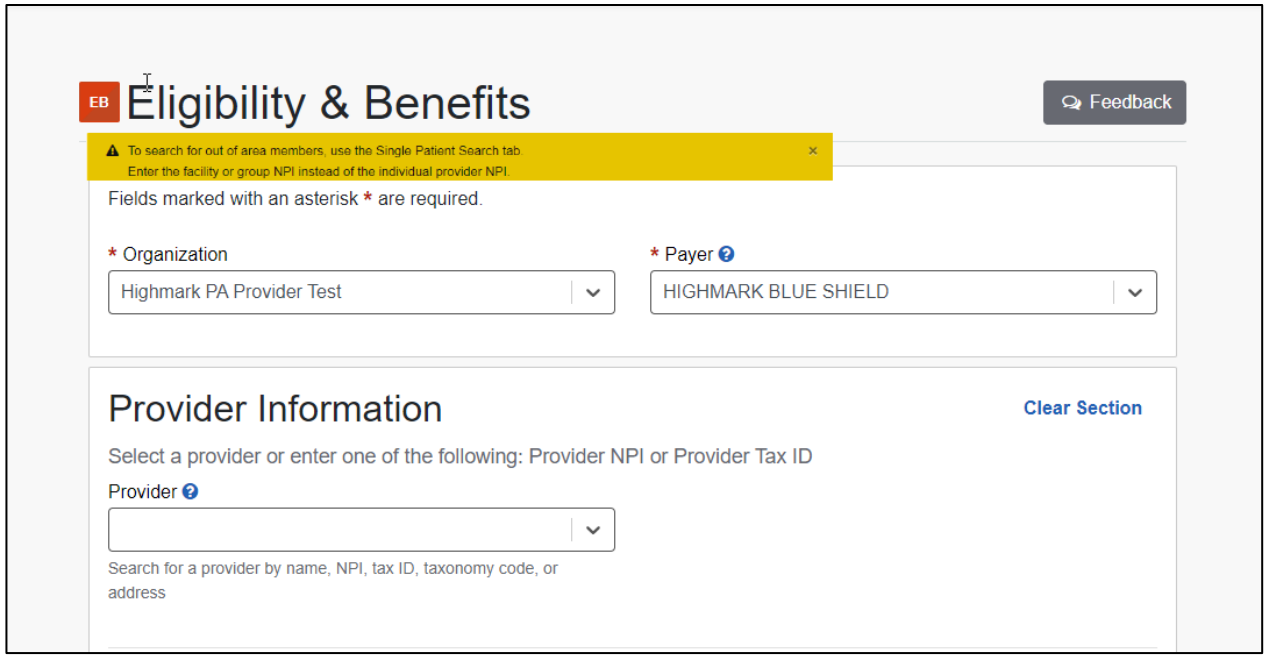
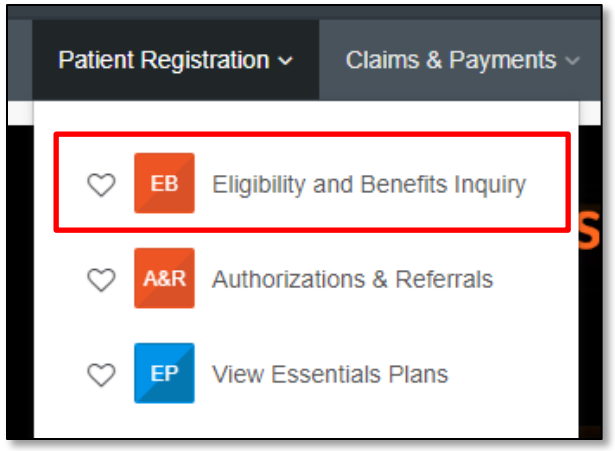
Availity® Provider Portal Outpatient Authorization Submission

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.

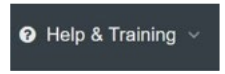




*Verifying Eligibility and Benefits prior to submitting a prior authorization request and/or submitting a claim can:

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

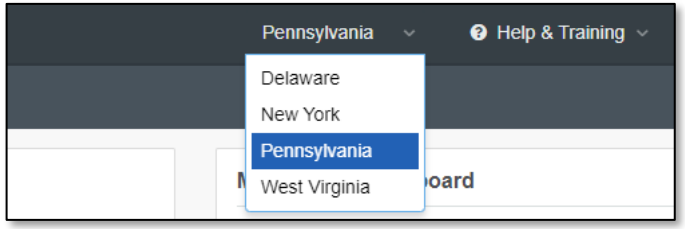
For additional assistance on Eligibility & Benefits Inquiry in Availity, go to Help & Training in Availity Essentials.



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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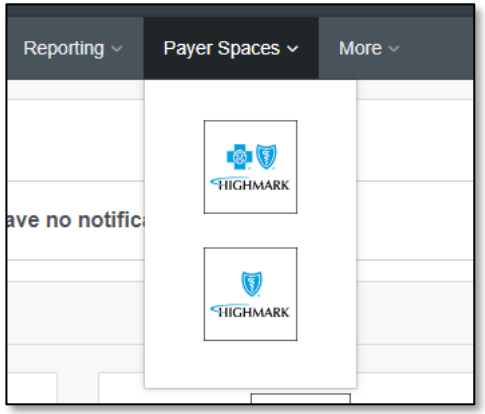
Path 1

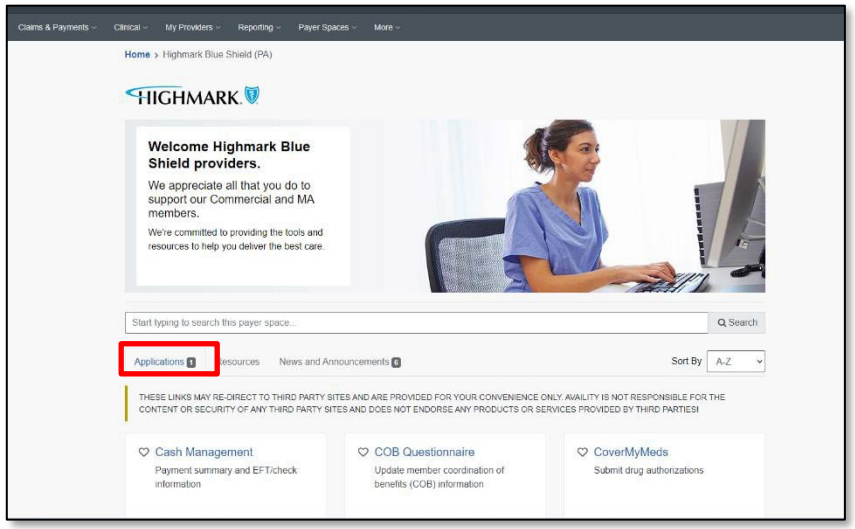
To access Highmark's Payer Spaces in Availity Essentials, click on **Payer Spaces** from the top menu and choose the appropriate Health Plan.

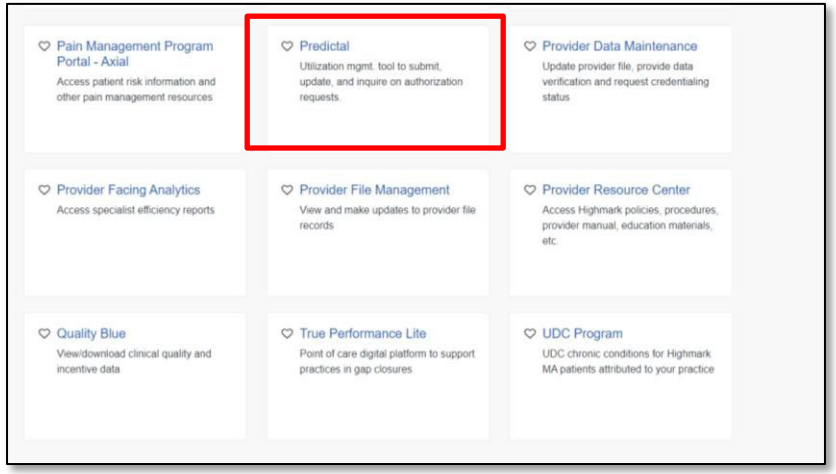


***For prior authorization requests for Retail Pharmacy, you must use this path for submission.**

***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.**



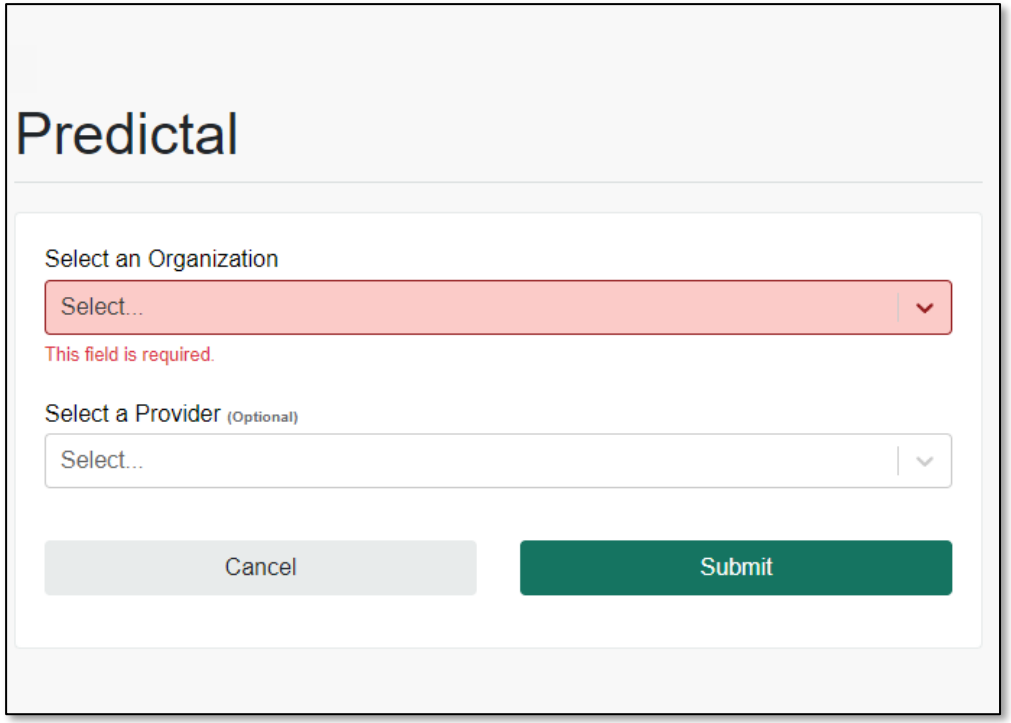


HIGHMARK | HIGHMARK

Path 1

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

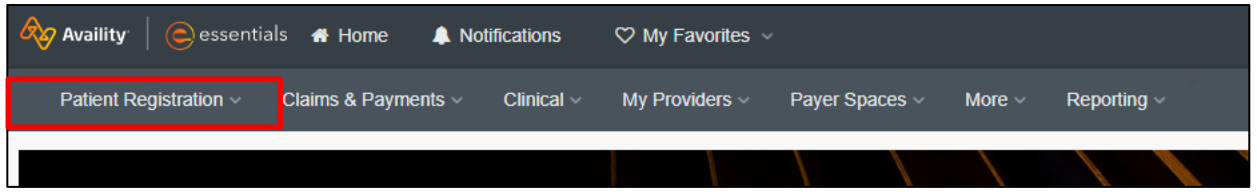
- Select a **Provider** (optional)
- Click **Submit** to get to a new tab.



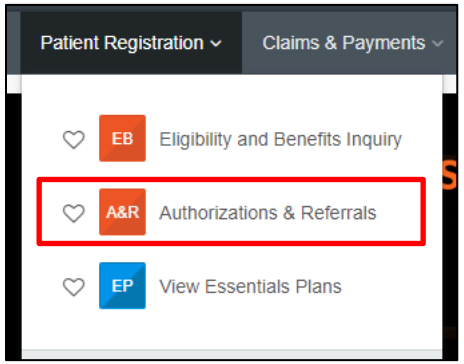
That will take you into the Predictal Authorization Automation Hub to complete your prior authorization request.

Path 2

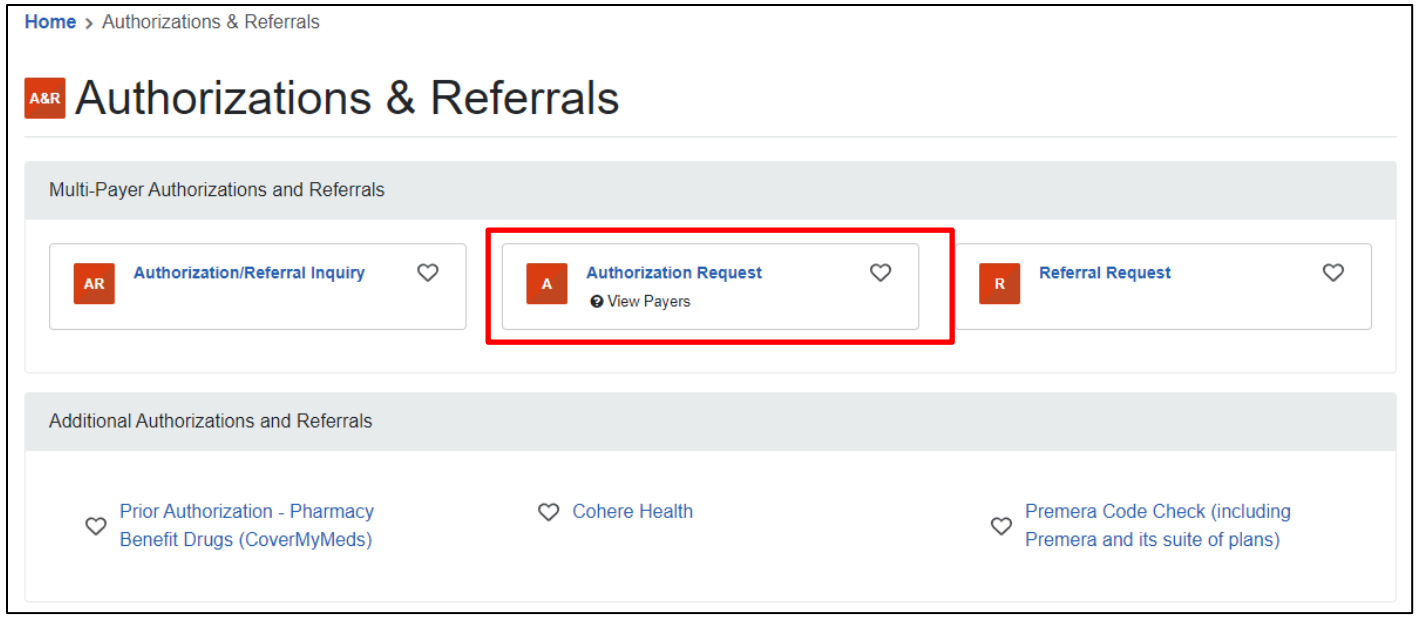
To access Authorization & Referrals, first click on Patient Registration in the top menu.



Then choose Authorizations & Referrals.



And select Authorization Request.



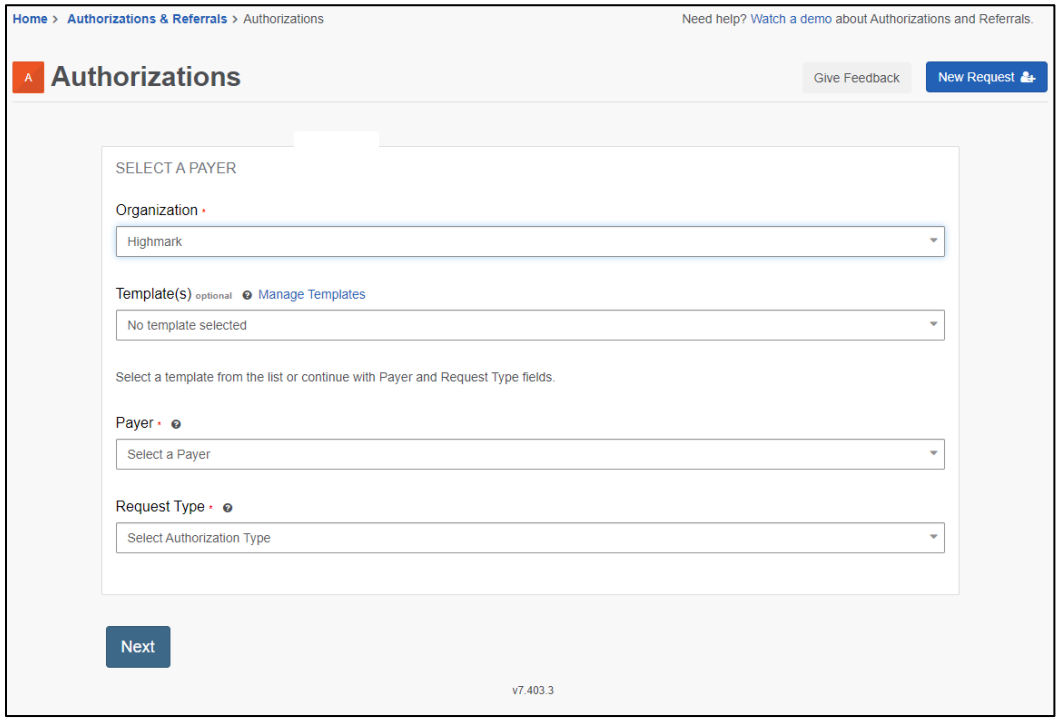
***For prior authorization requests for Out of Area members, you must use this path for submission.**

HIGHMARK | HIGHMARK

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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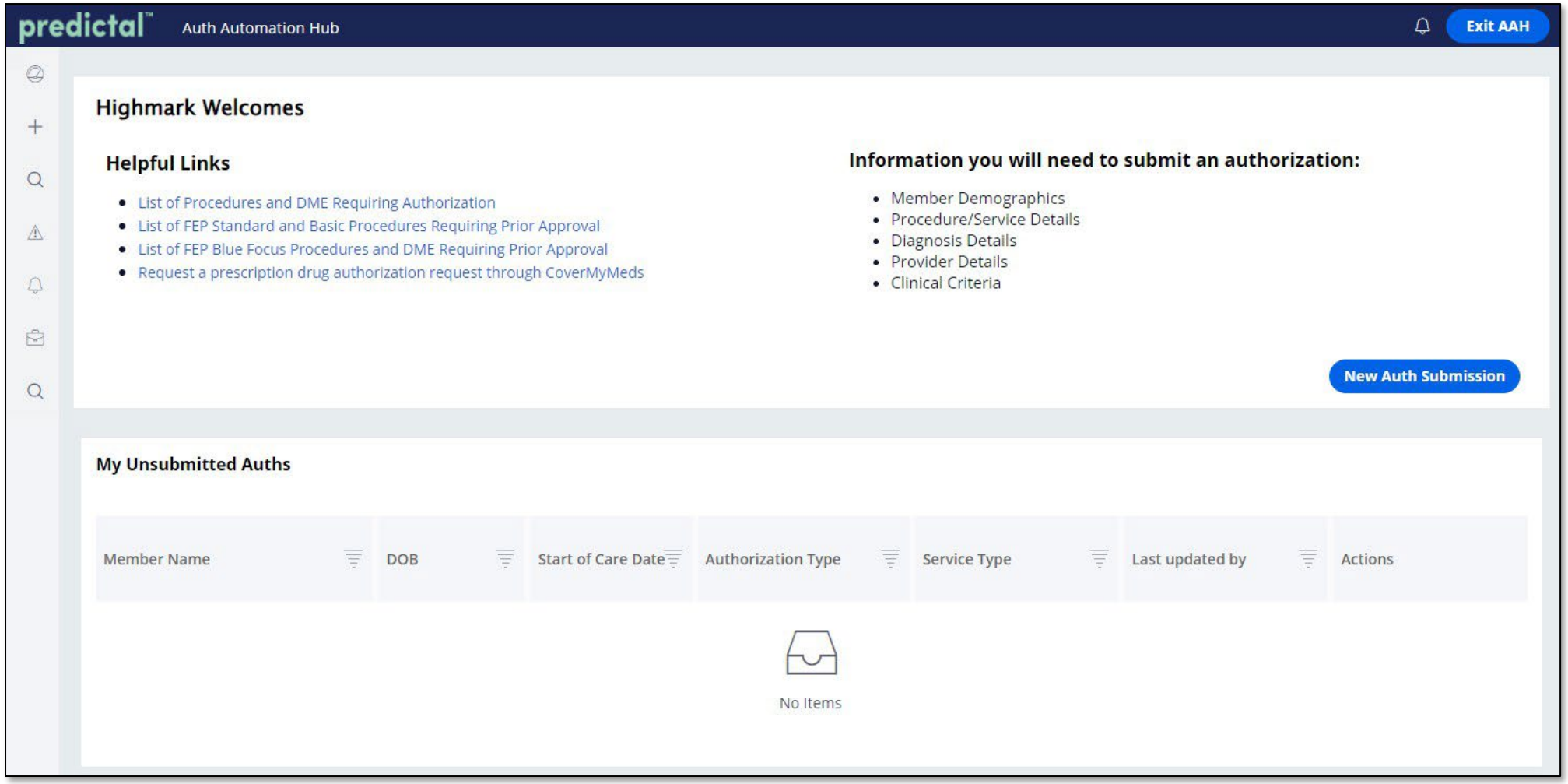
Authorization requests for the following outpatient services may be completed within the Predictal Auth Automation Hub, which is accessible via Payer Spaces:

Outpatient – Planned Medical
Outpatient – Planned Surgical
Outpatient – Speech Therapy
Outpatient – CORF – Physical Therapy
Outpatient – CORF – Occupational Therapy Home Health Care
Hospice Pharmacy

Outpatient – Large Join Procedures
Outpatient – Spine Surgery Procedures
Outpatient – Pain Management Procedures
Outpatient – Medical Drug and Chemotherapy
Advanced and Cardiac Imaging – Request
Radiation Therapy – All Services
Lab Management – Genetic Testing

*Note: Workflows for the services listed above may not be accessible for providers in all Highmark regions.

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.

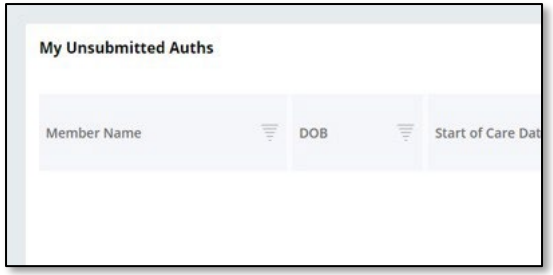
Select **New Auth Submission** to initiate a new request.

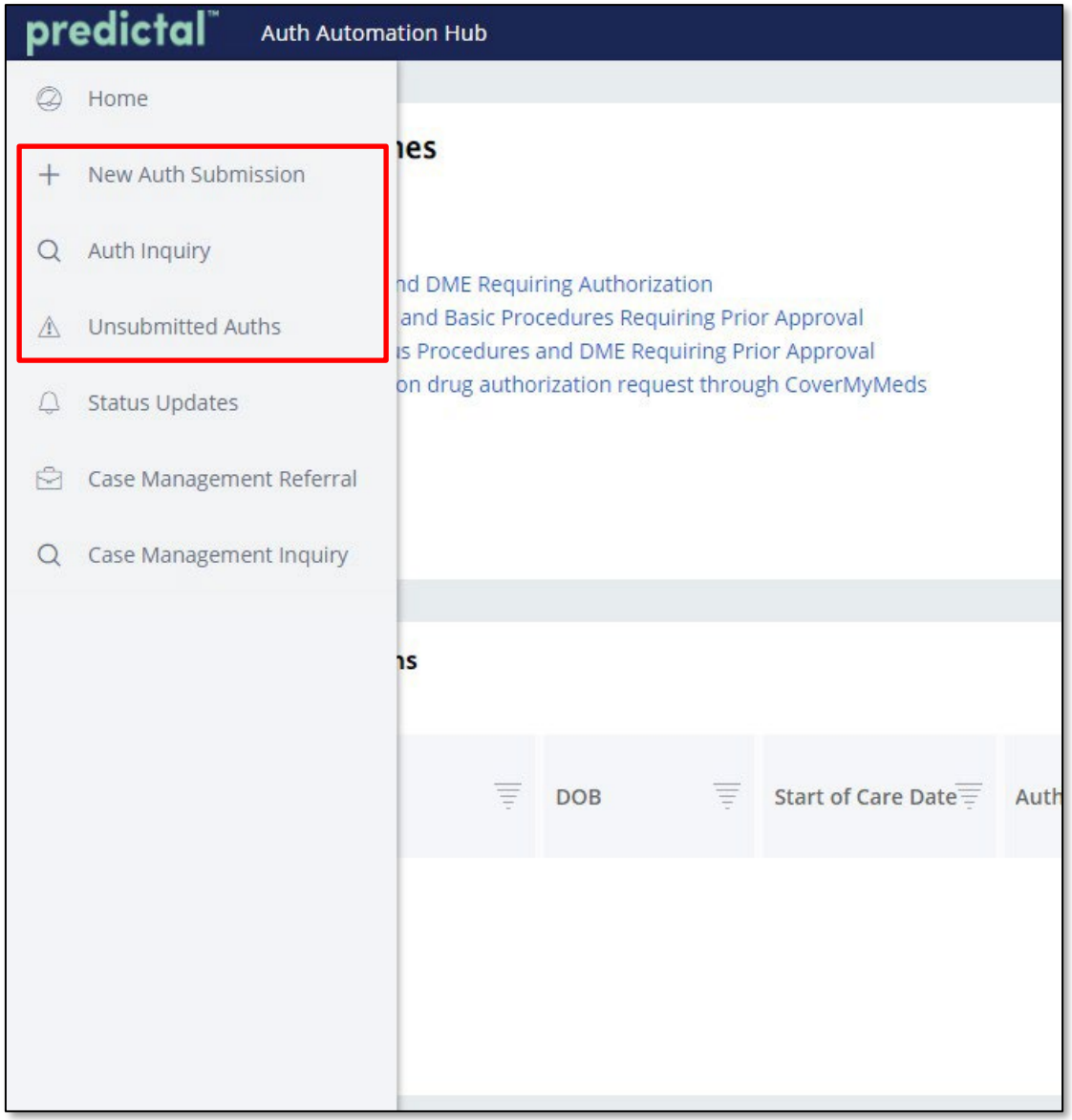
Select **Auth Inquiry** to do any of the following:

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.

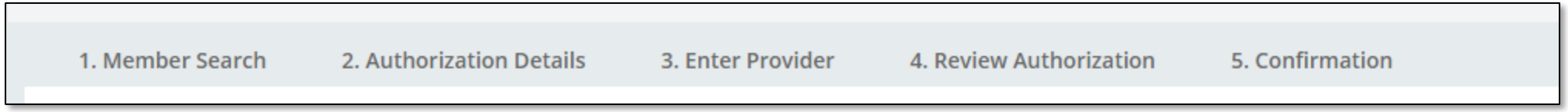
You can also view your **Unsubmitted Auths** on the Predictal homepage.





New Authorization Submission via Predictal

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

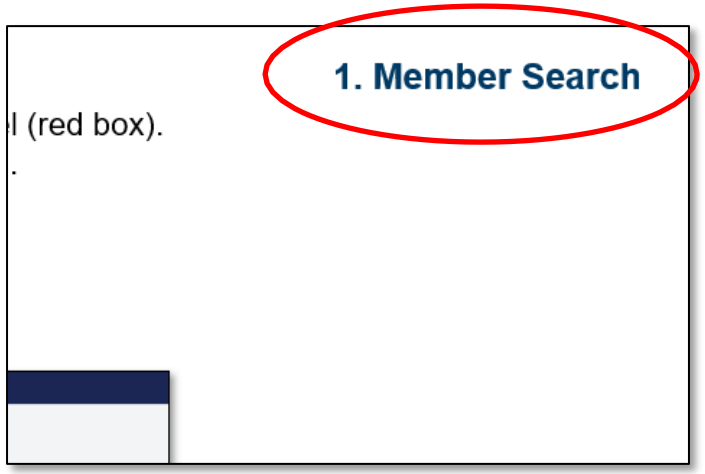


After each step listed in the top menu bar, you will be asked to hit **Submit**. Your authorization will not be submitted to Highmark until the final **Submit** on the Confirmation screen (Step 5 above.)

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.

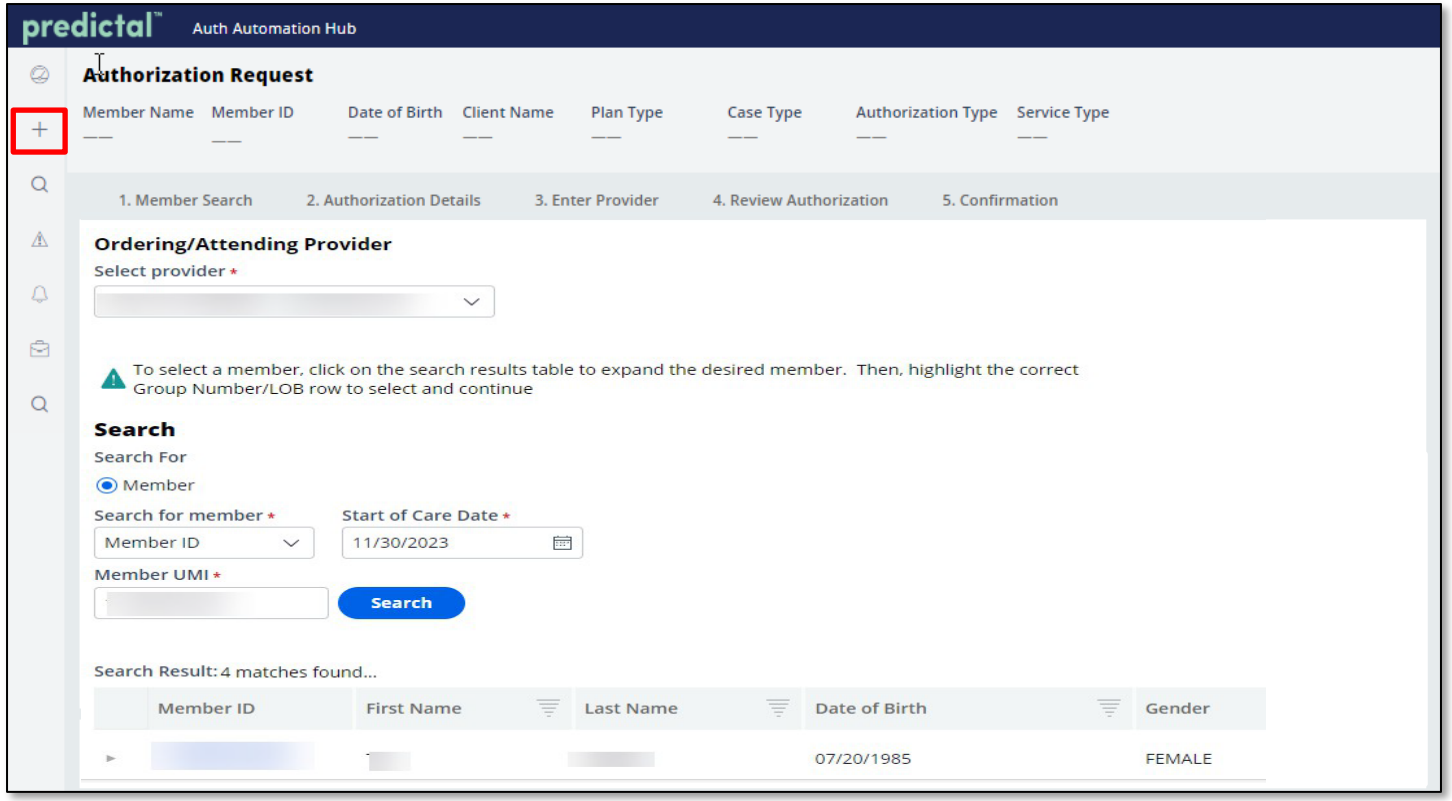


1. Member Search

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.



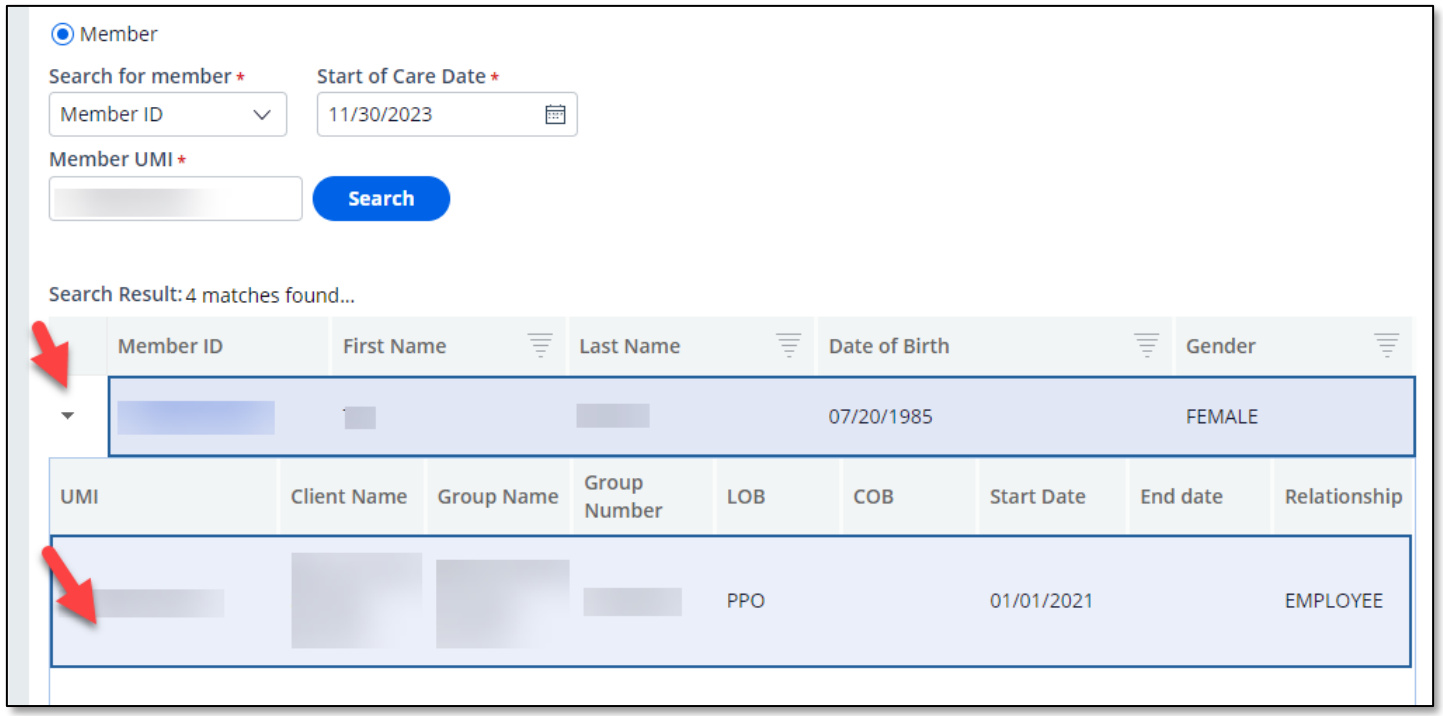
1. Member Search

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.

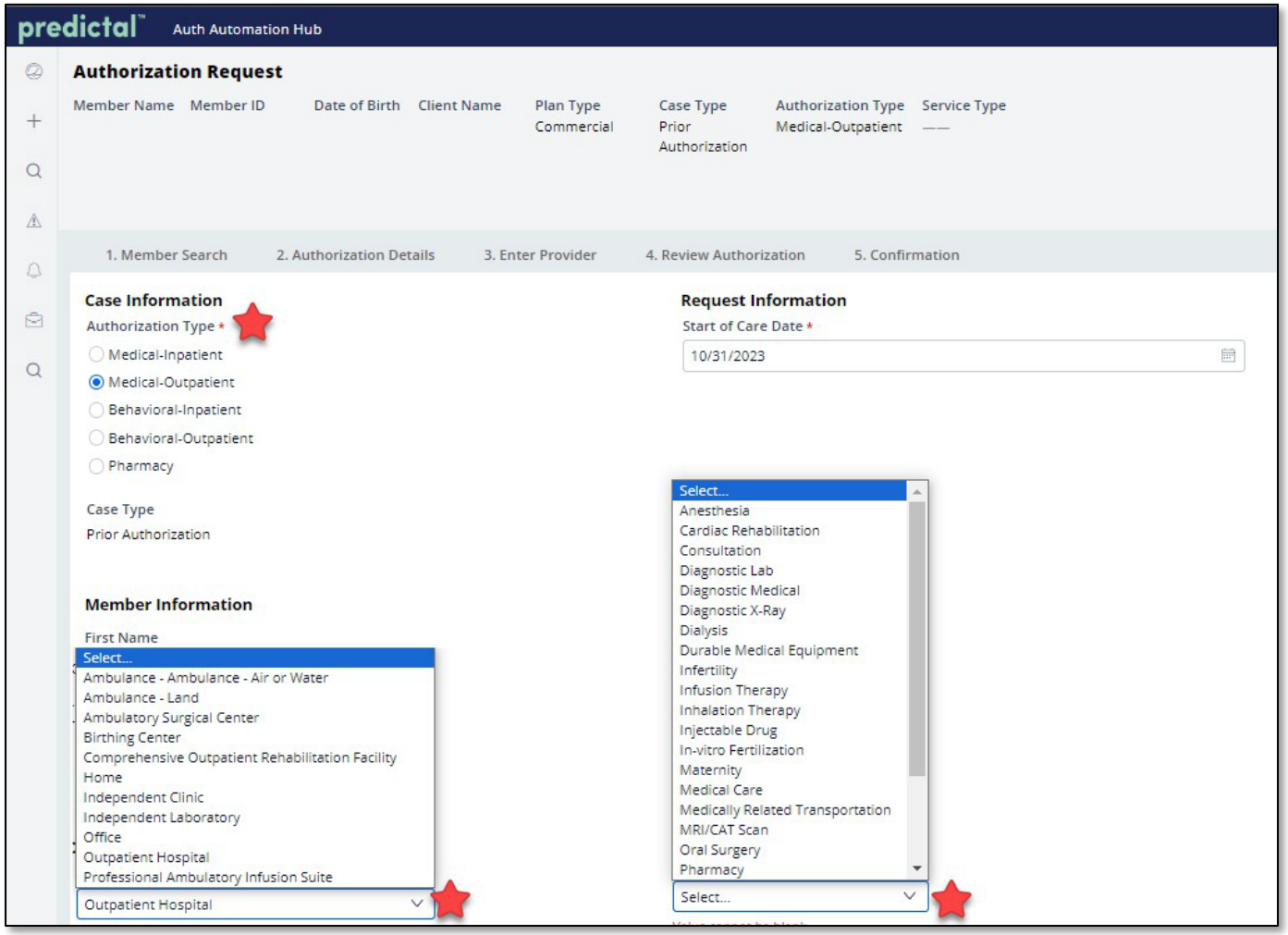
You can then select **Submit** to move to the next step.



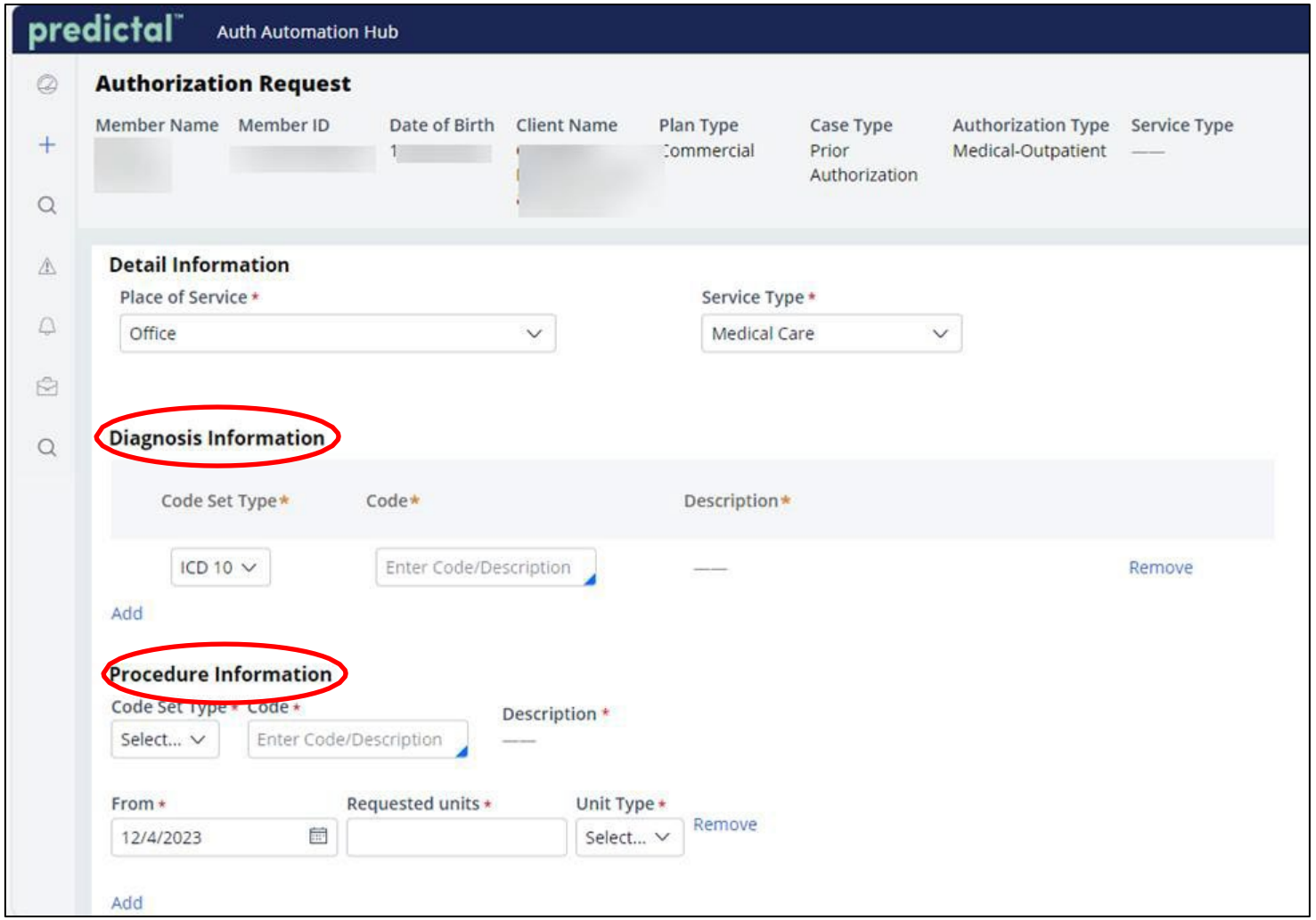
2. Authorization Details

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

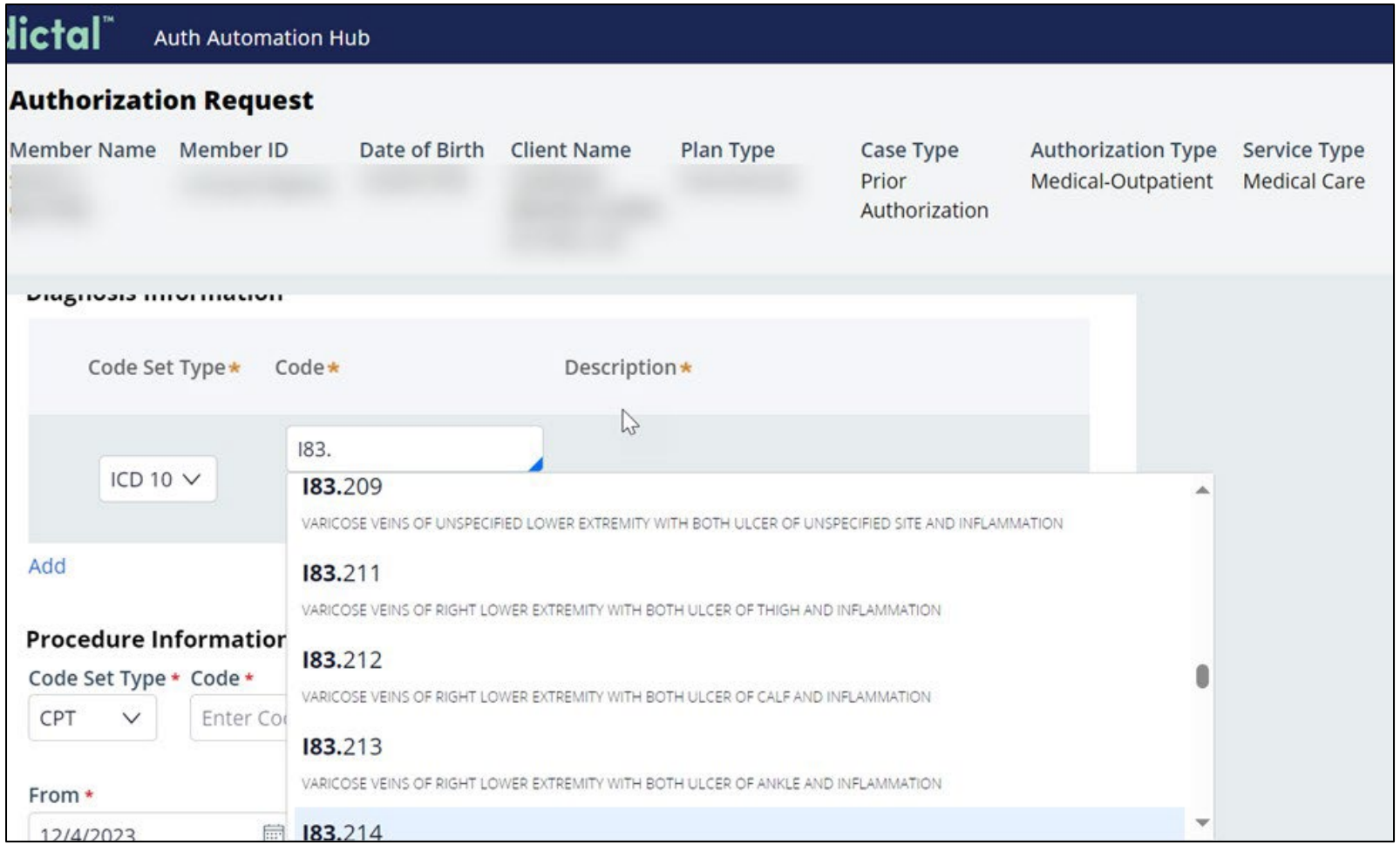
3. Select the Authorization Type
4. Select the Place of Service
5. Select the Service Type



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

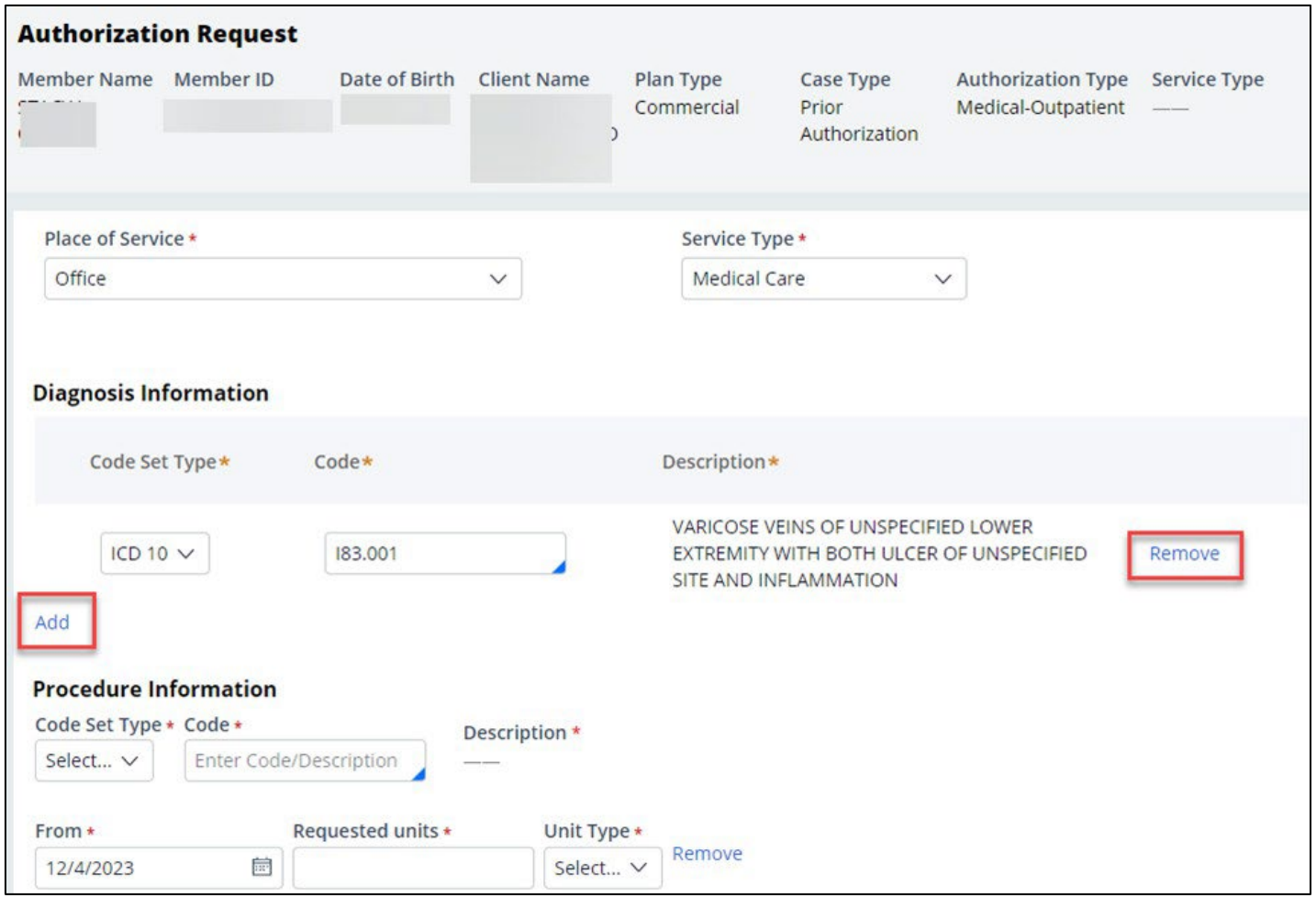


In the **Diagnosis Information** section – entering a partial diagnosis code or description will populate a list of codes for you to select from. You must include the **decimal point** when entering your **diagnosis** code.



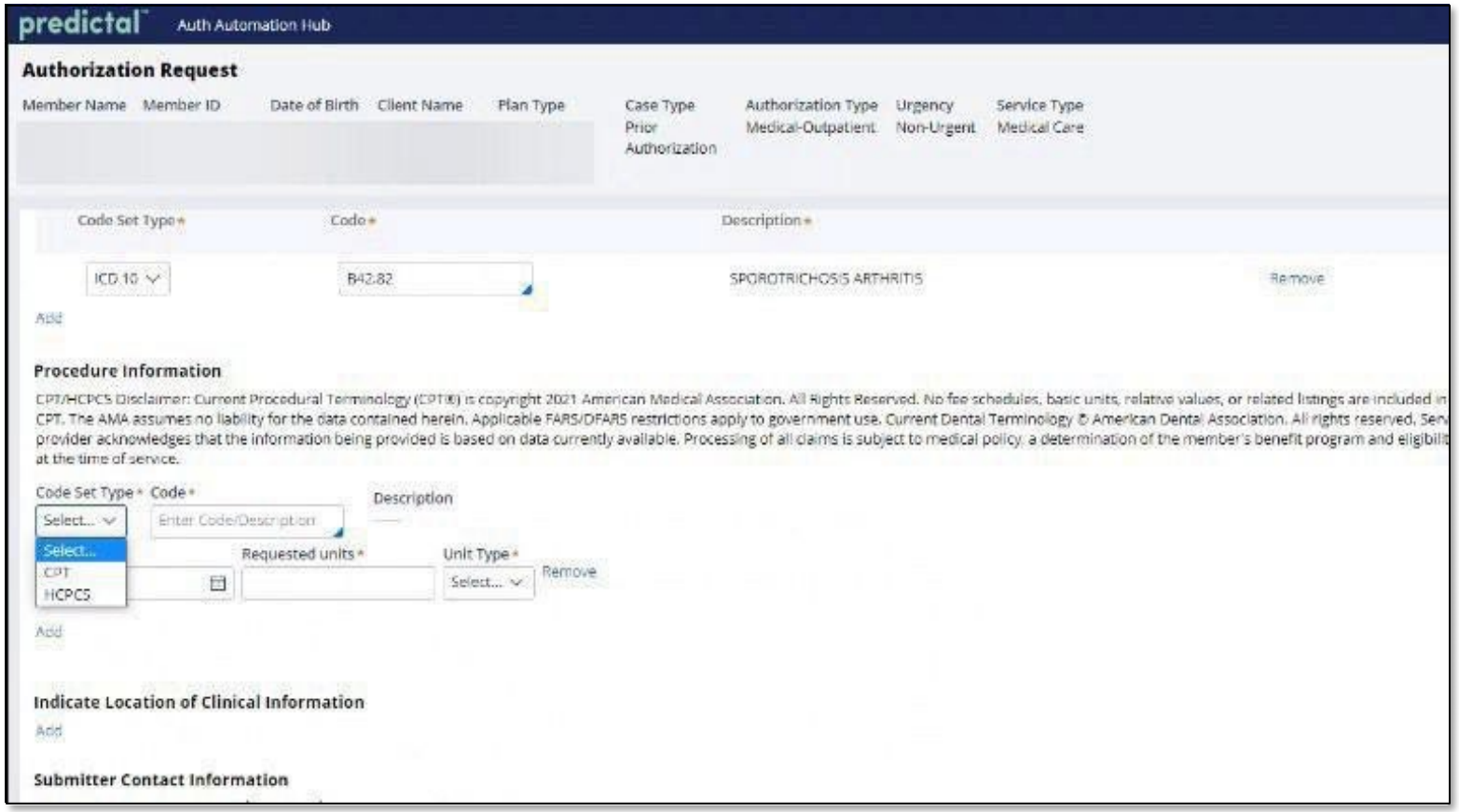
If you have entered an incorrect code, you can click the **Remove** link to delete that diagnosis from the request. Select the **Add** link to add additional diagnosis codes.

NOTE: eviCore managed authorizations will only allow one diagnosis code to be added.



Whenenteringthe **Procedure** information, you **must** selectthe appropriate **Code Set Type**.If this is not selected,your procedure code will not be found.

NOTE: When entering an eviCore or Helion managed authorization, you will not be asked for the procedure code until later in the workflow.



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

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

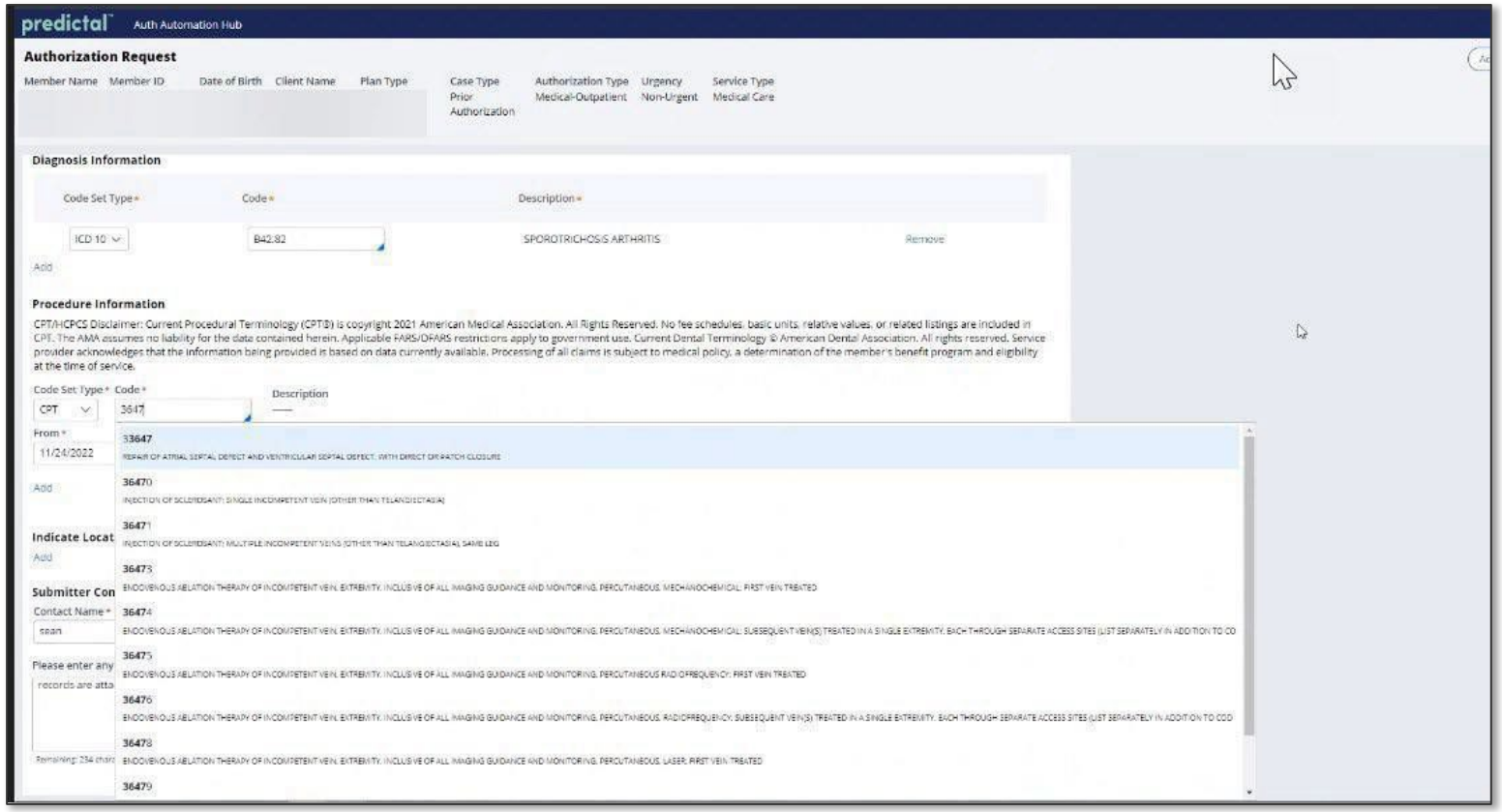
2. Authorization Details

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

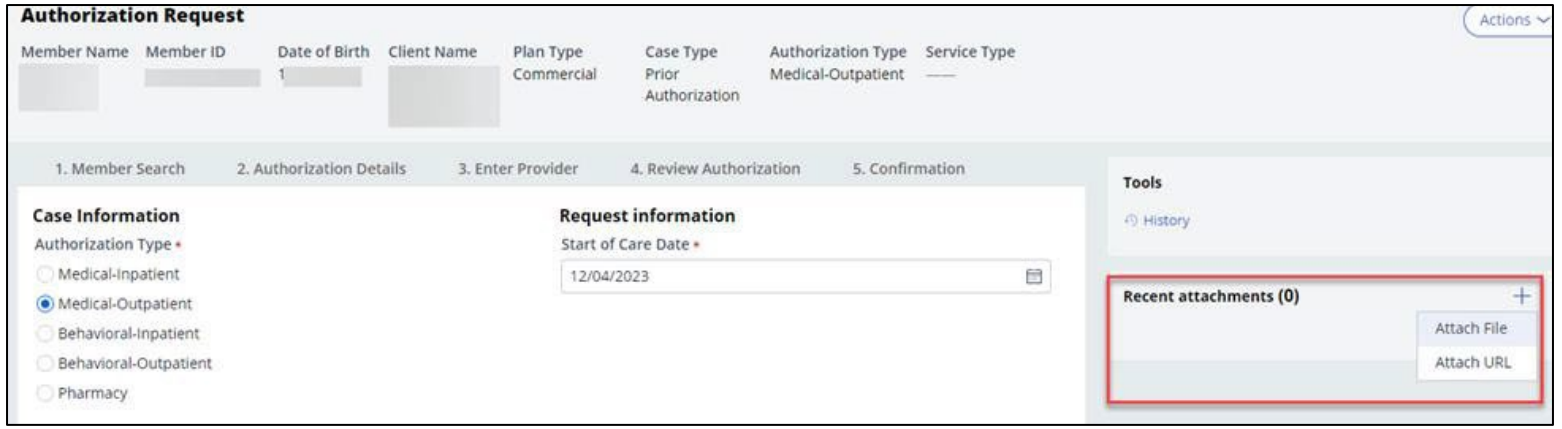
Next, complete the remaining required fields.

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.

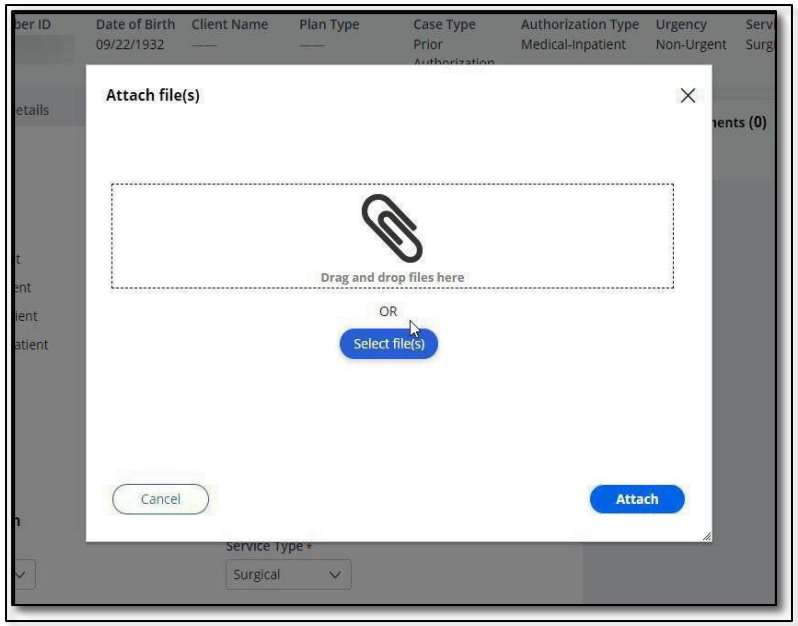
Note: There is no limit the number of procedure codes that can be added.

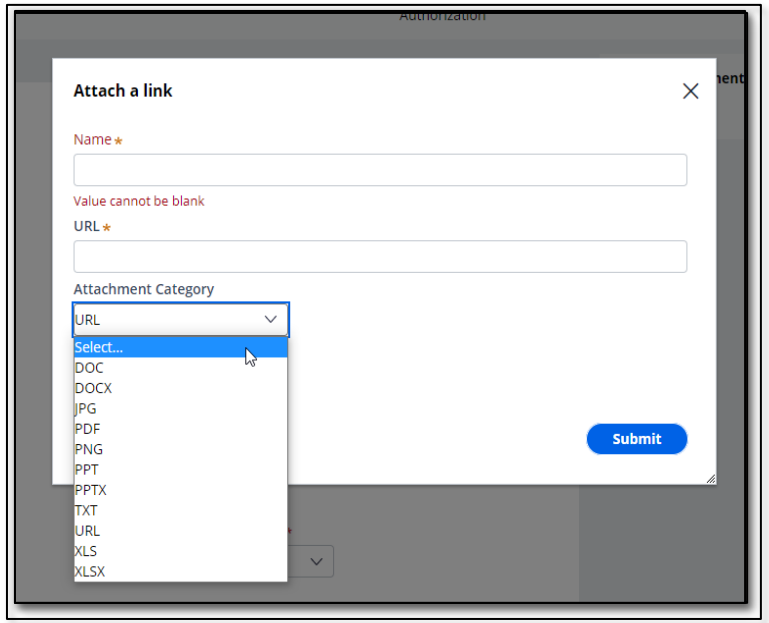


The **Recent Attachments section** will allow you to send attachments with an authorization by clicking on the **+ icon**.

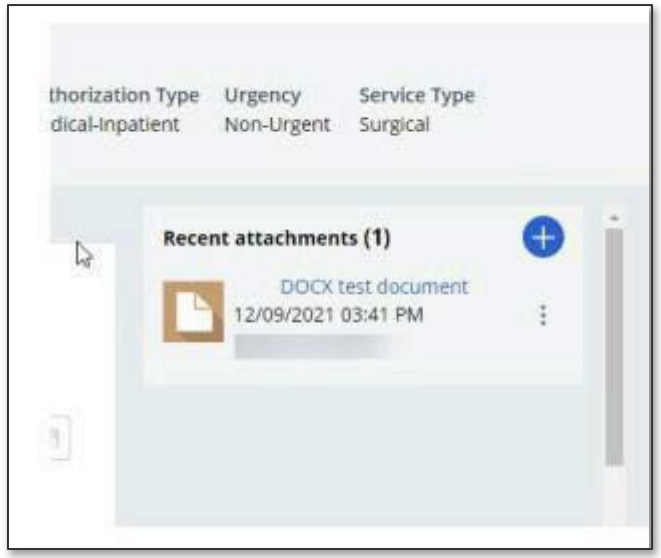


You can also attach a file or a URL in the **Recent Attachments** section.



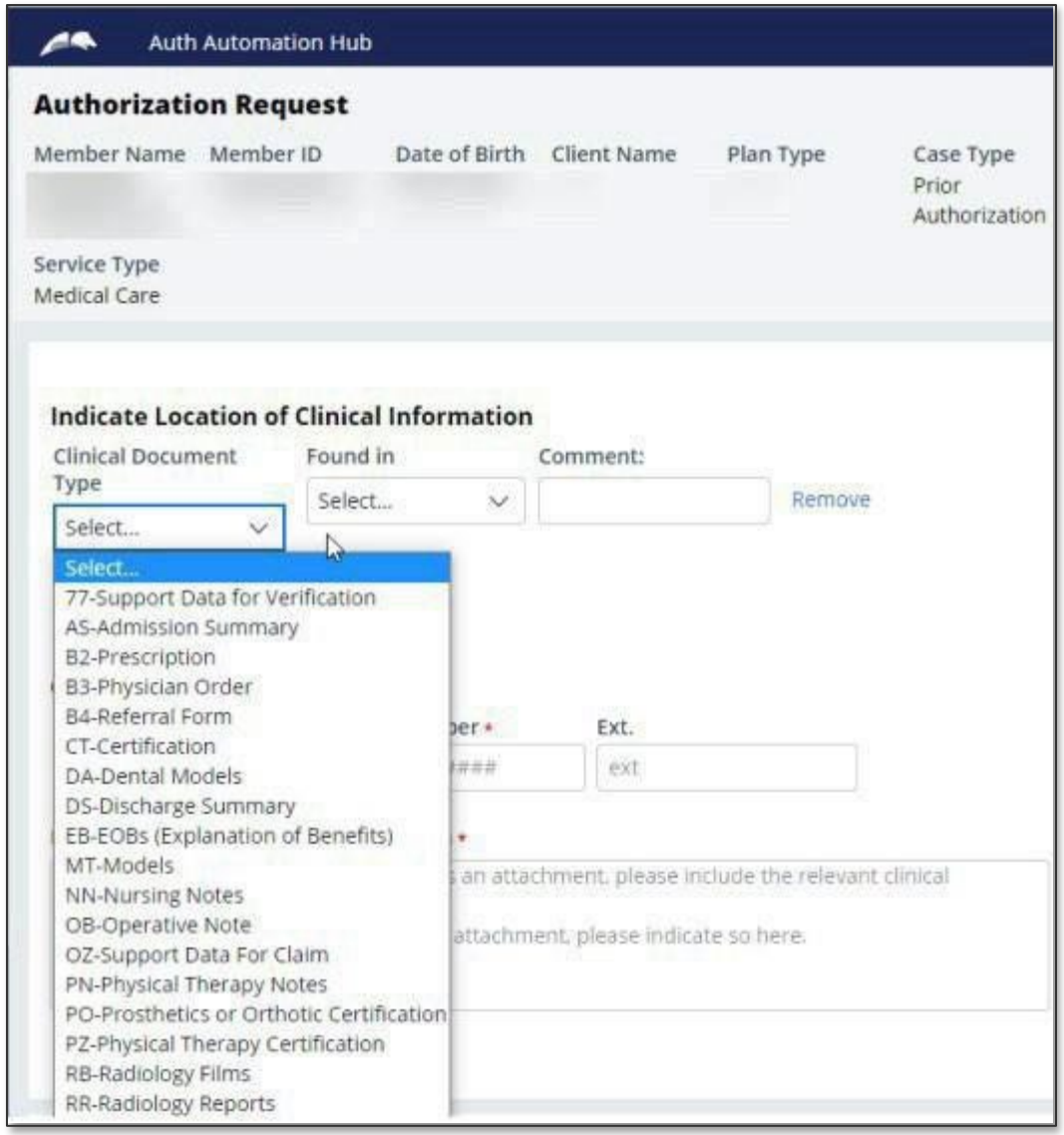


2. Authorization Details



When a document has been attached in the **Recent Attachment** section, you should complete the **Indicate Locations of Clinical Information** sectionto provide additional information about 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

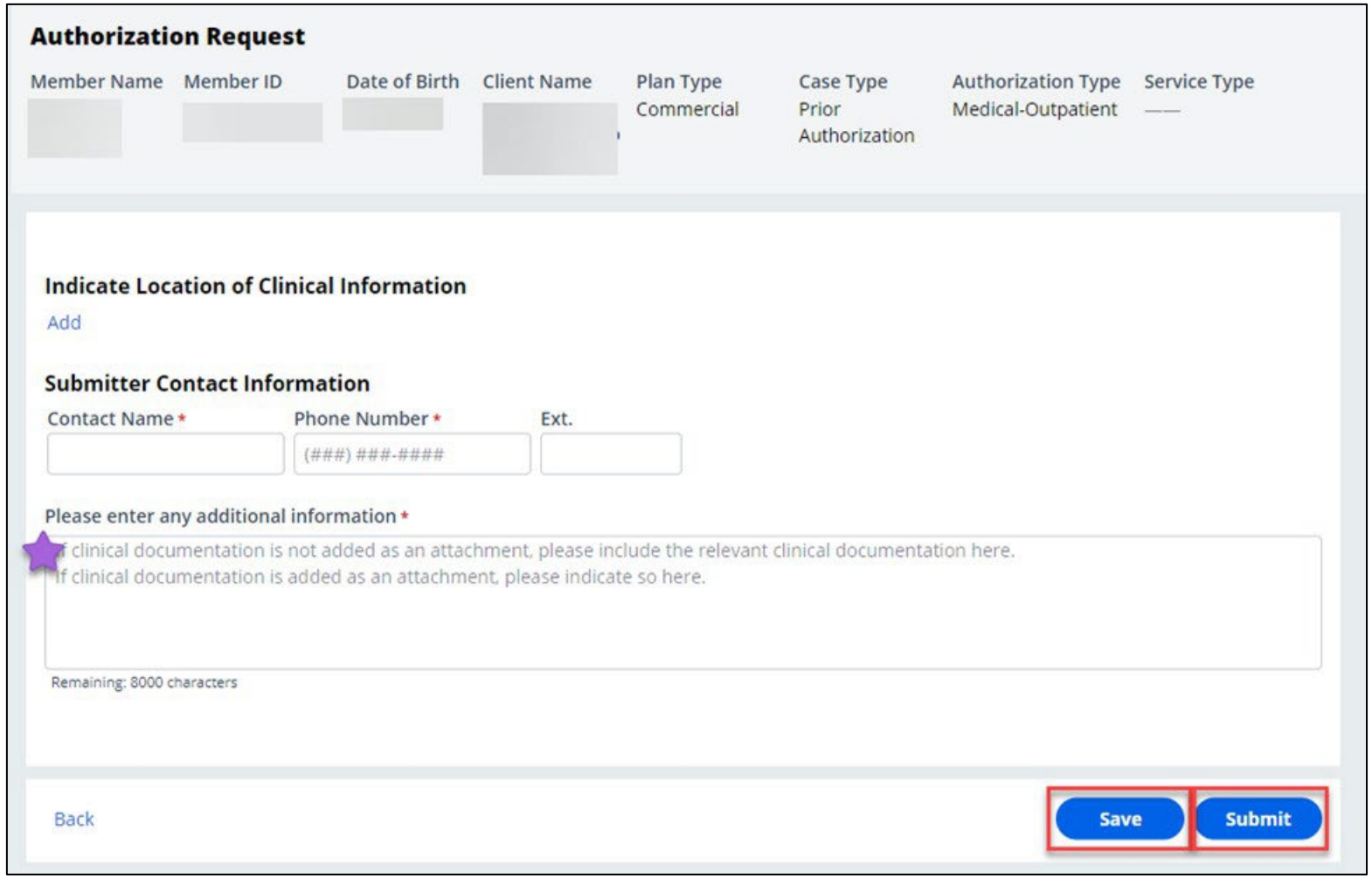


Completing the **Caller Information** section by:

- Noting any additional clinical information (there is a 225-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.

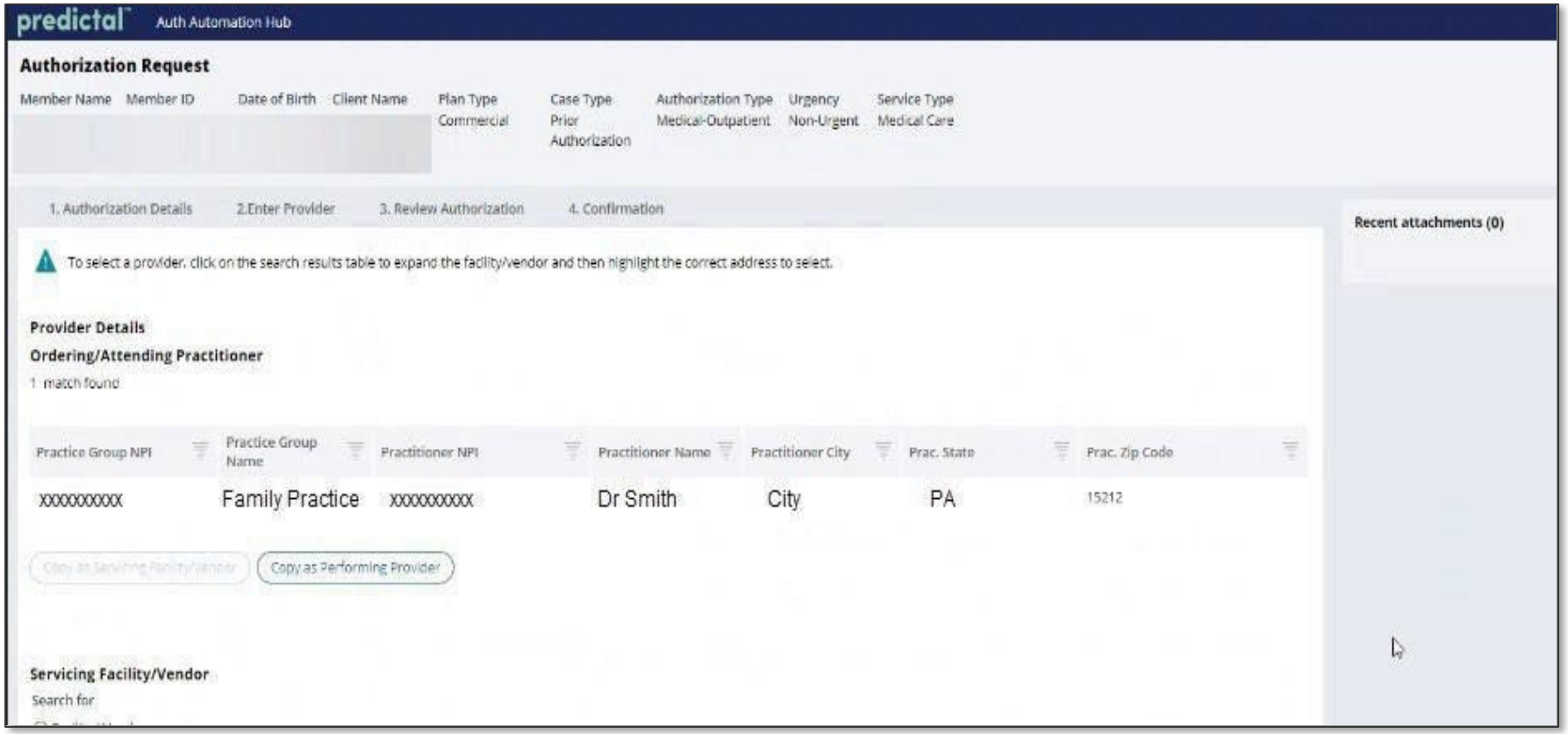
When all fields are complete, click **Submit.**



3. Enter Provider

The **Provider Details** page, will automatically populate with the Ordering/Attending Practitioner that was selected previously. Select **Search** to choose the ordering/attending providers location.

Here you will find the **Copy As Servicing Facility/Vendor** / **Copy As Performing Provider** link that will allowyou to copy the **Ordering/Attending Practitioner** information into the **Servicing Facility/Vendor** or **Performing Provider** information.



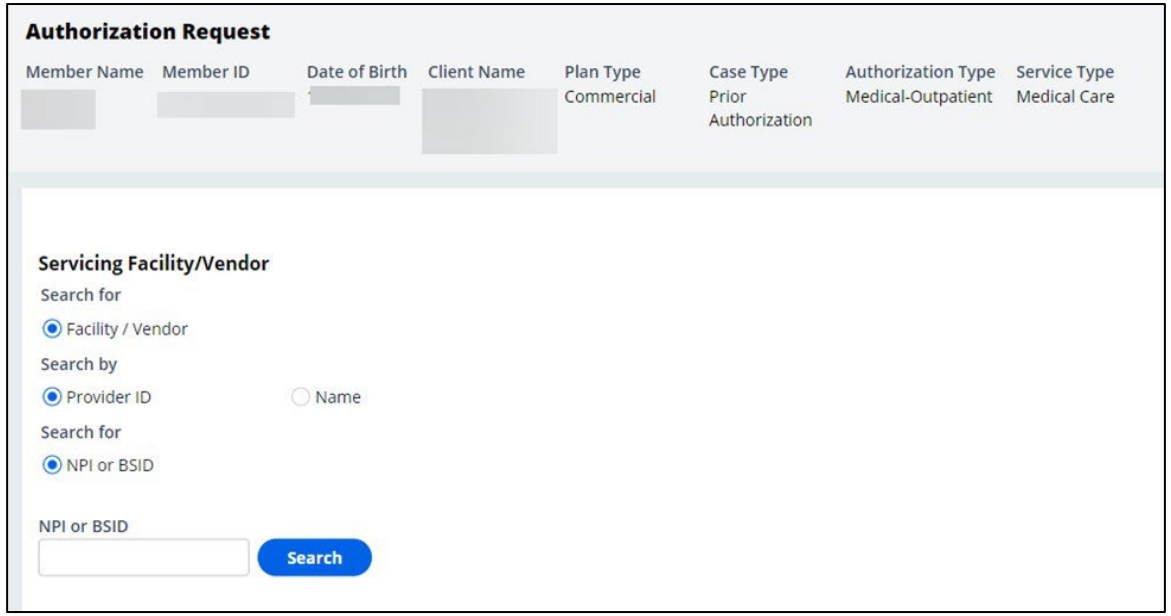
3. Enter Provider

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

Search for the **Servicing Facility/Vendor** by:

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

This is a **mandatory** field.



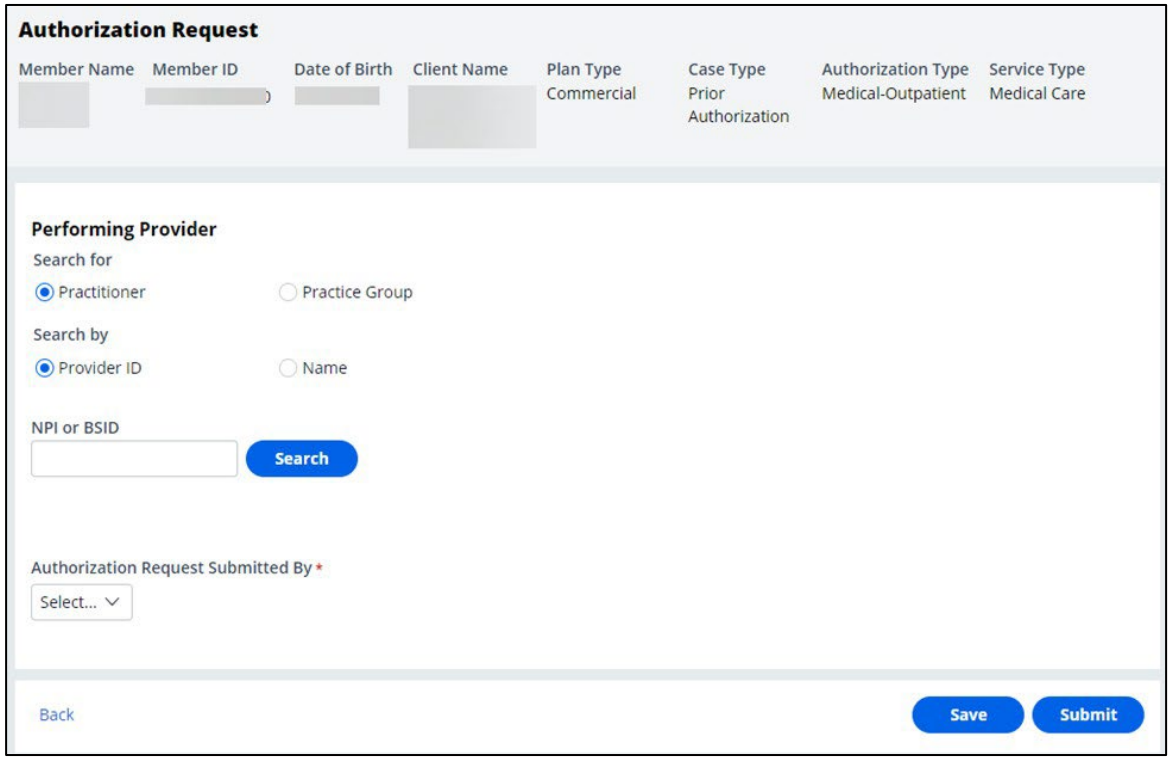
Search for the **Performing Provider** by: Practitioner using:

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

(or) Practice Group using:

- Provider ID (using NPI, BlueShieldID or Tax ID)
- Name

This is a **mandatory** field.



3. Enter Provider

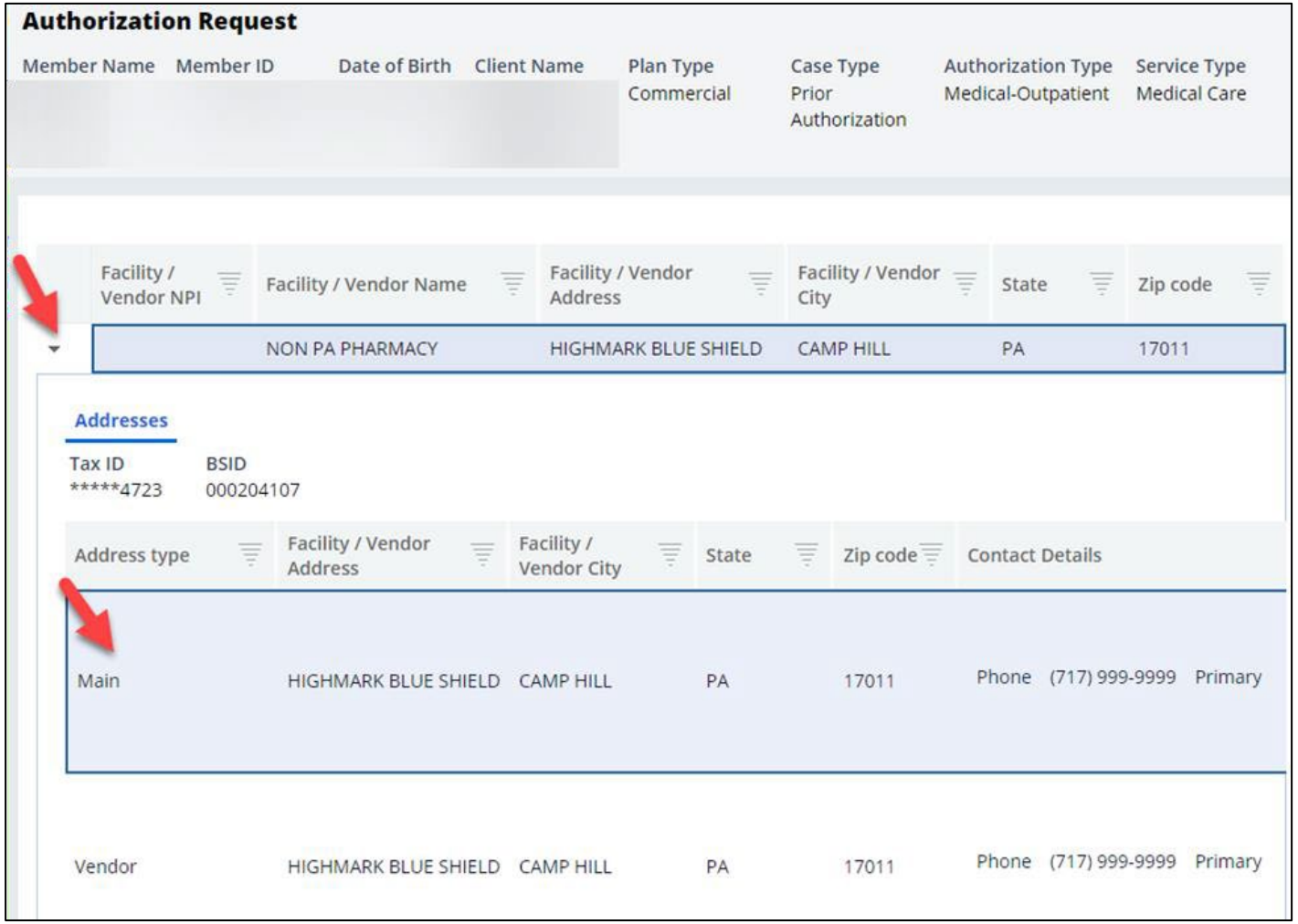
When results return, to select the appropriate facility/vendor, you will need to complete the following steps to select the specific facility/vendor.

- 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.

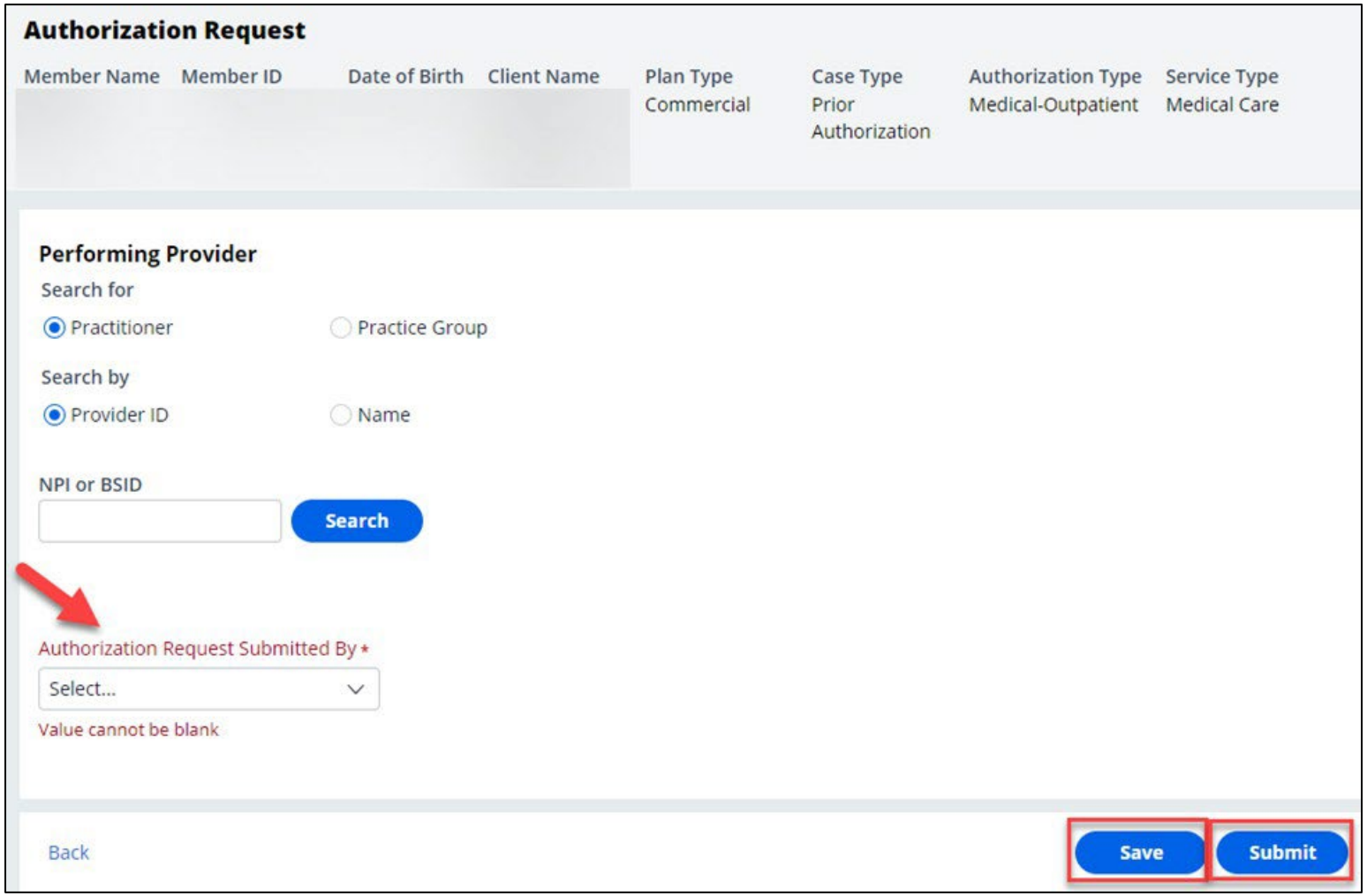
Note: You will need to repeat these same steps for **Performing Provider**.



3. Enter Provider

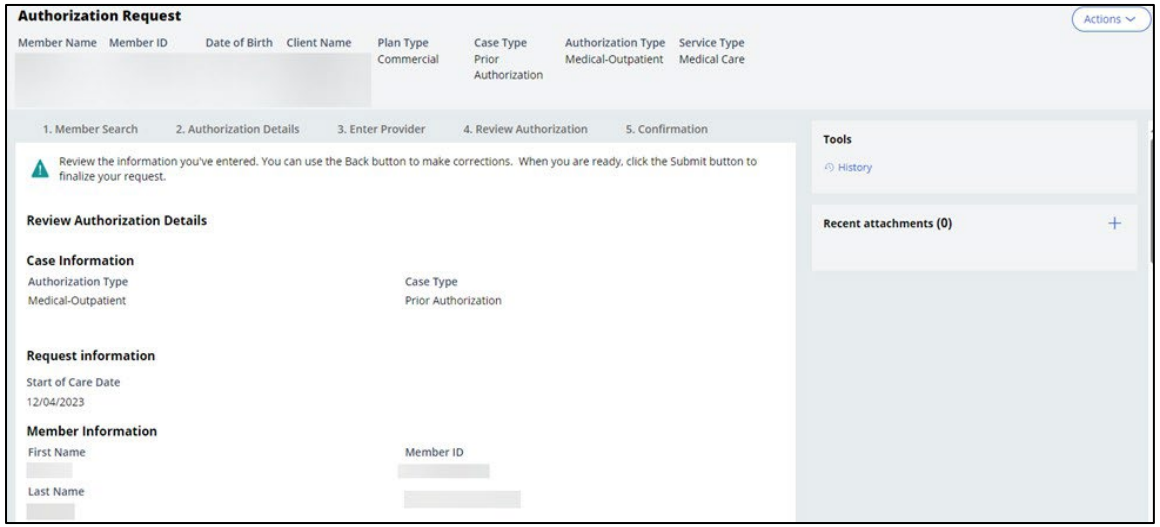
Select the provider who is requesting the authorization in the **Authorization Request Submitted By** drop down.

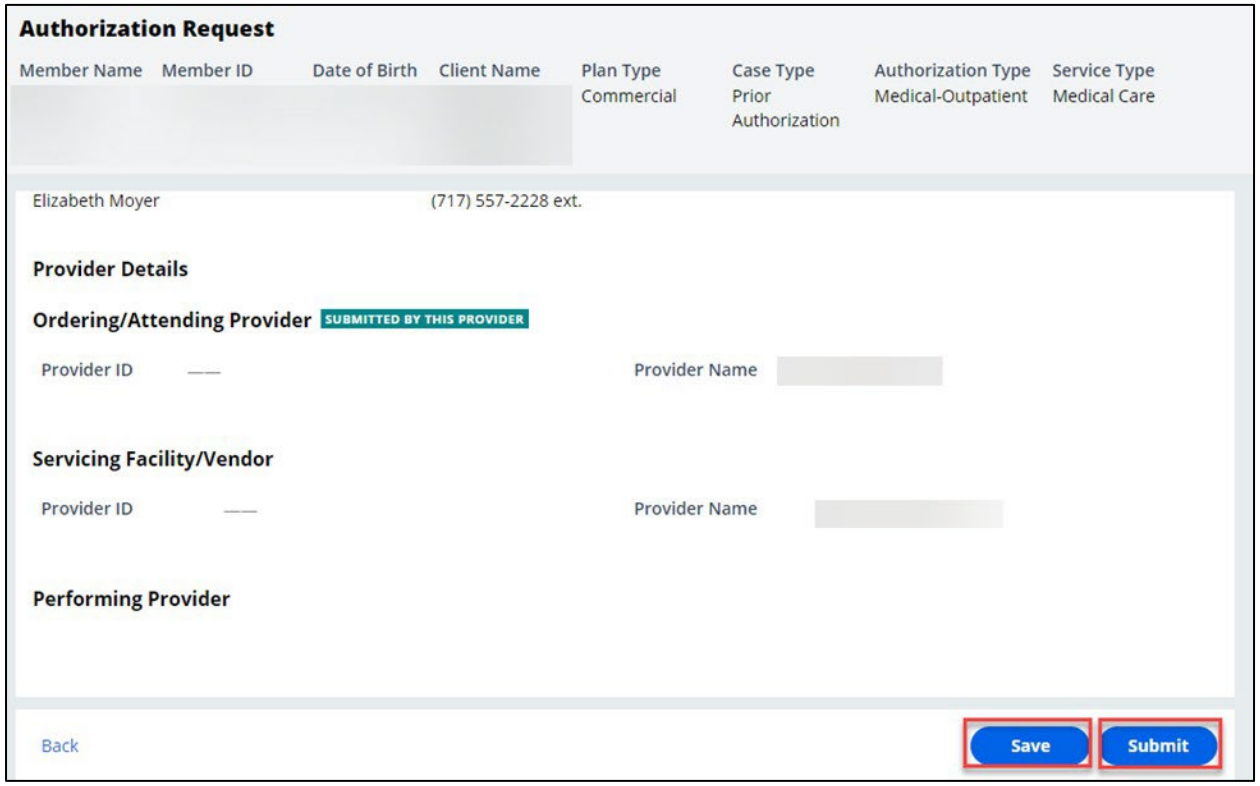
Click **Submit** when all information has been completed.



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.

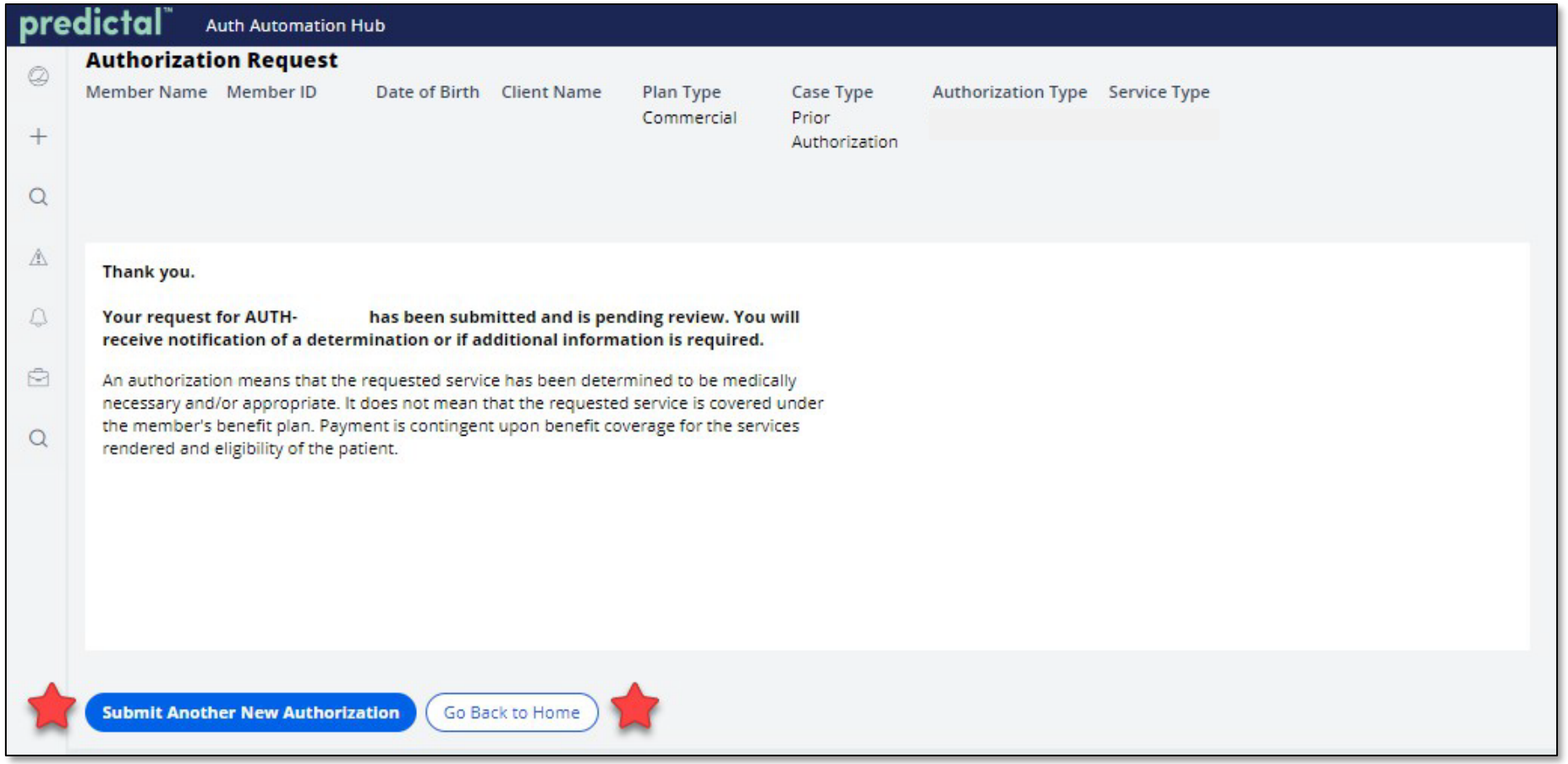




5. Confirmation

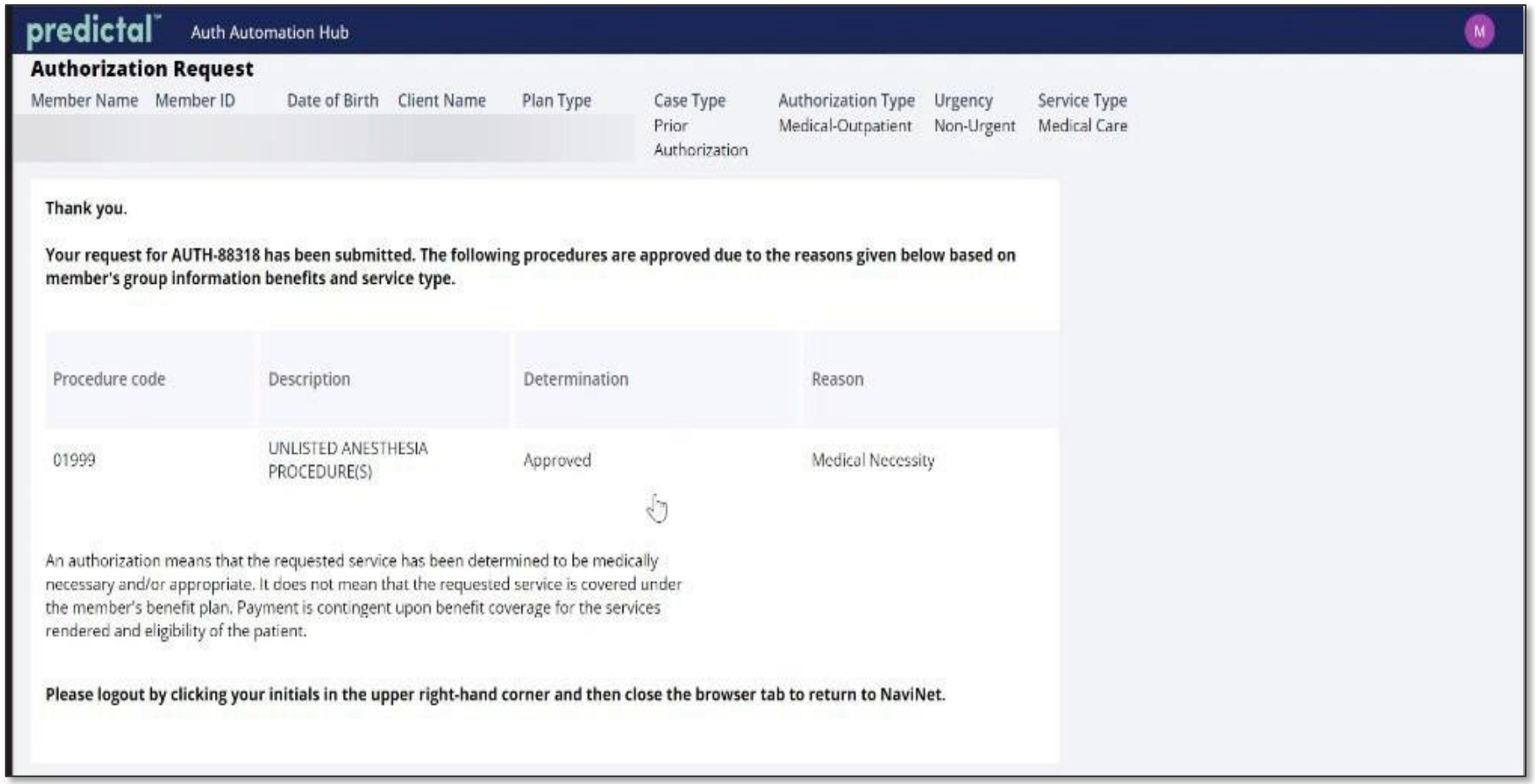
When the authorizationis submitted, a confirmation will be displayed on the page with the **Authorization Number**.

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

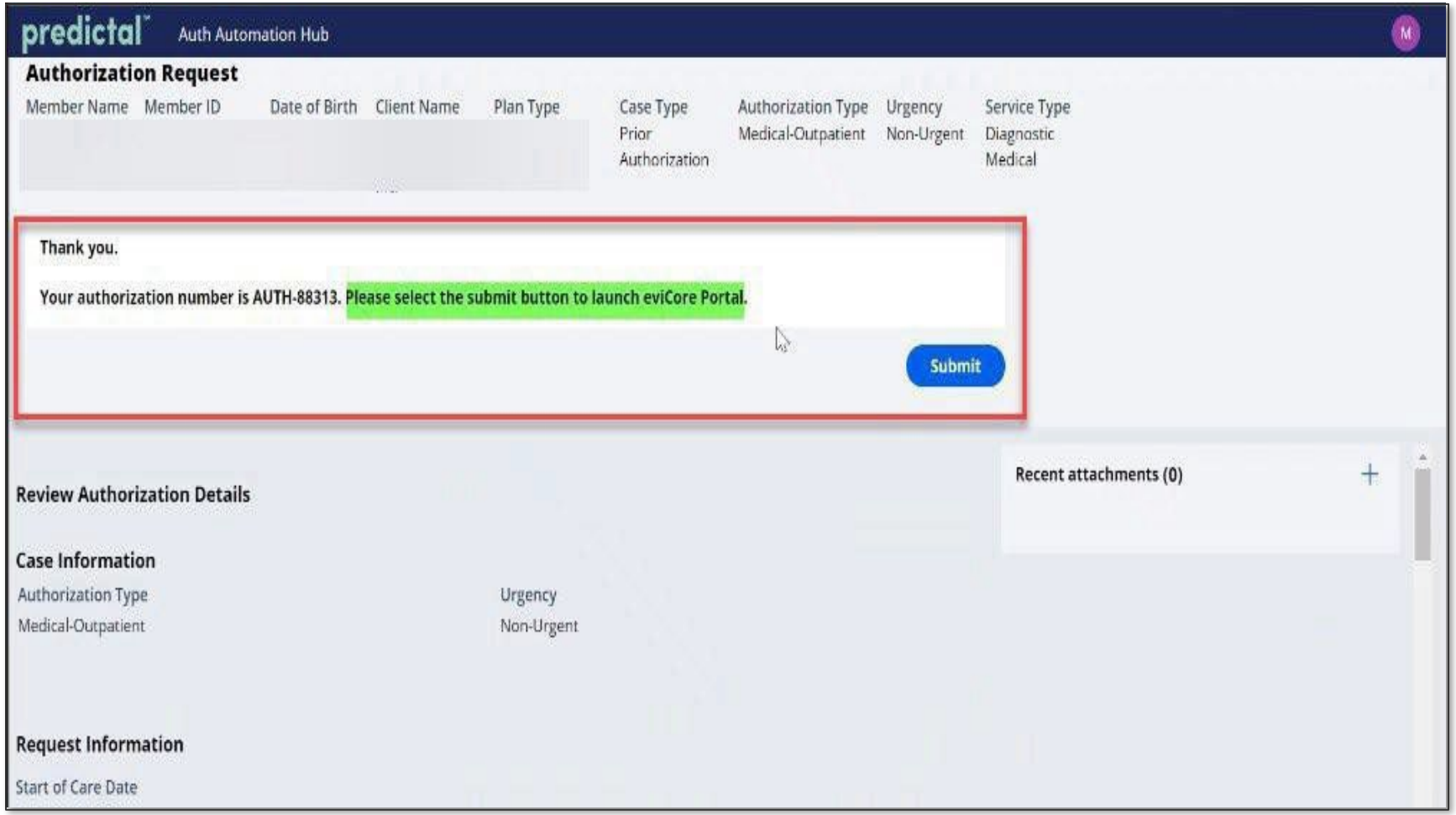


5. Confirmation

The screen below will be displayed when an authorization is auto-approved.

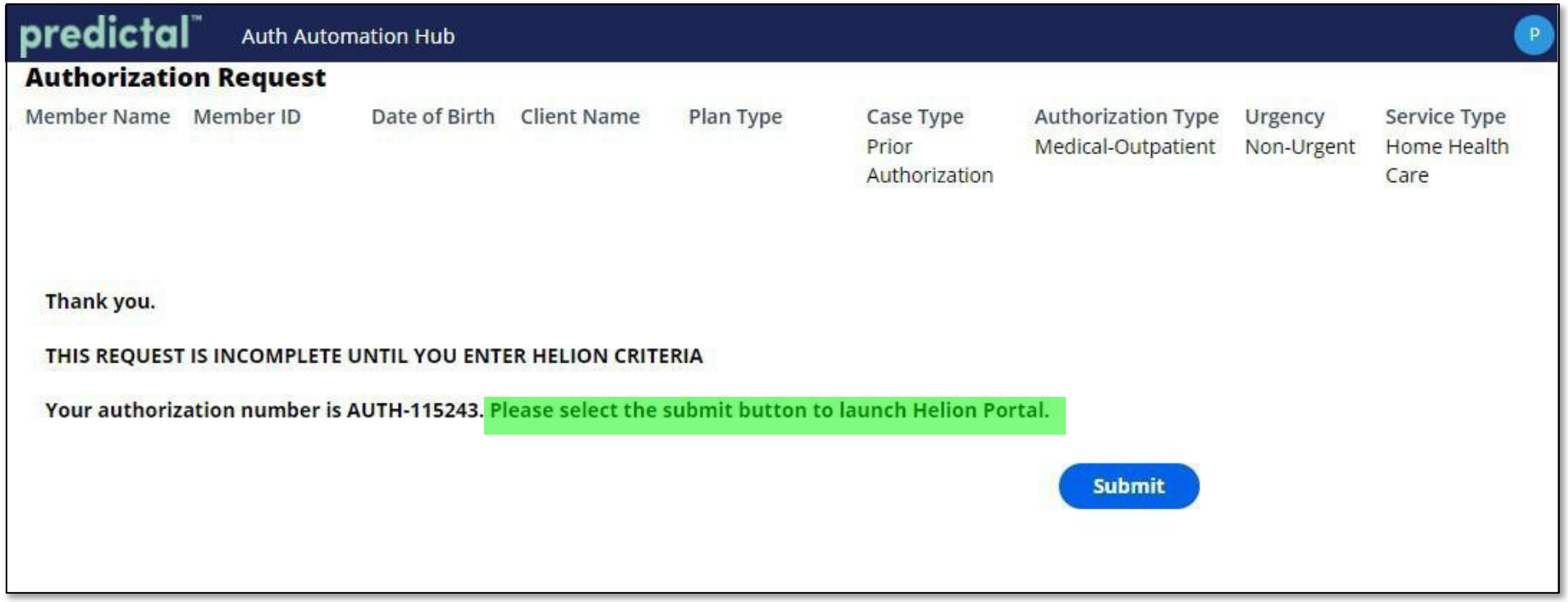


Please note: When submitting an **eviCore-Managed Authorization**, be sure to click **Submit** to launch to the eviCore portal.



Please note: When submitting Home Health/Hospice, or certain outpatient therapy requests, be sure to click **Submit** to launch to the Helion Portal.

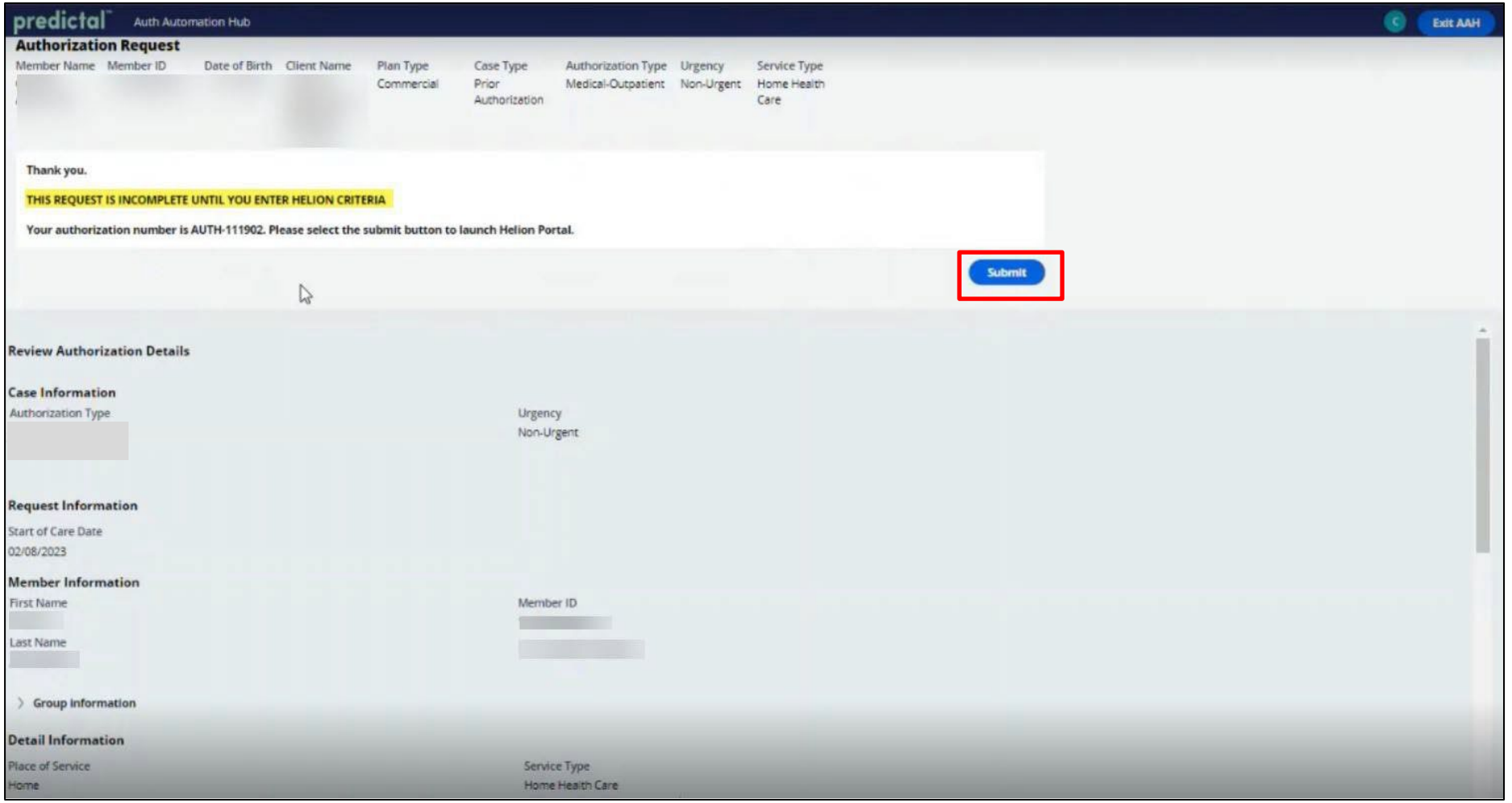
Additional information Helion Arc begins on the next page of this guide.



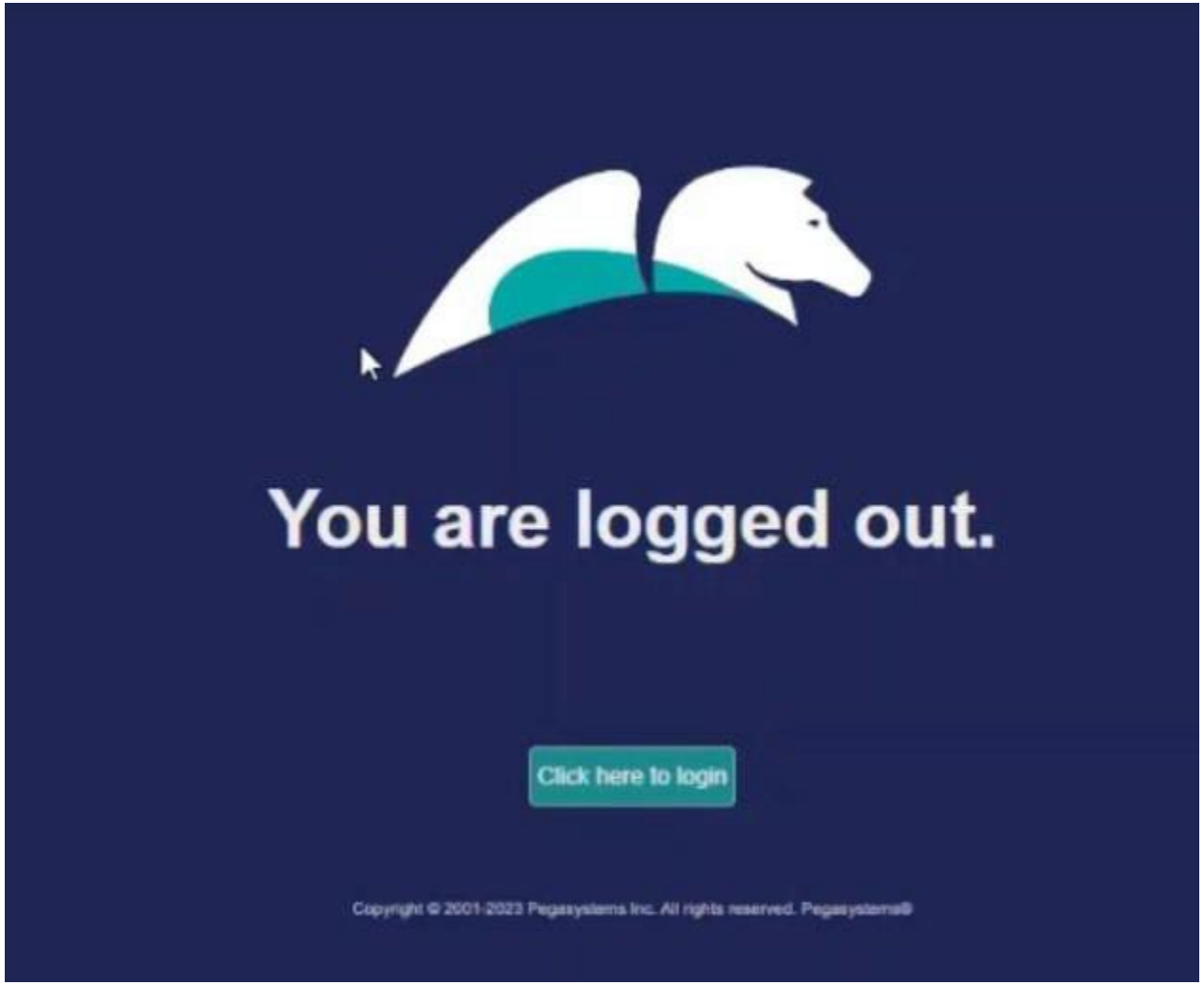
Helion Arc Authorization Submission

You will get a notification that the request is incomplete until Helion criteria is entered.

Hit **Submit**.



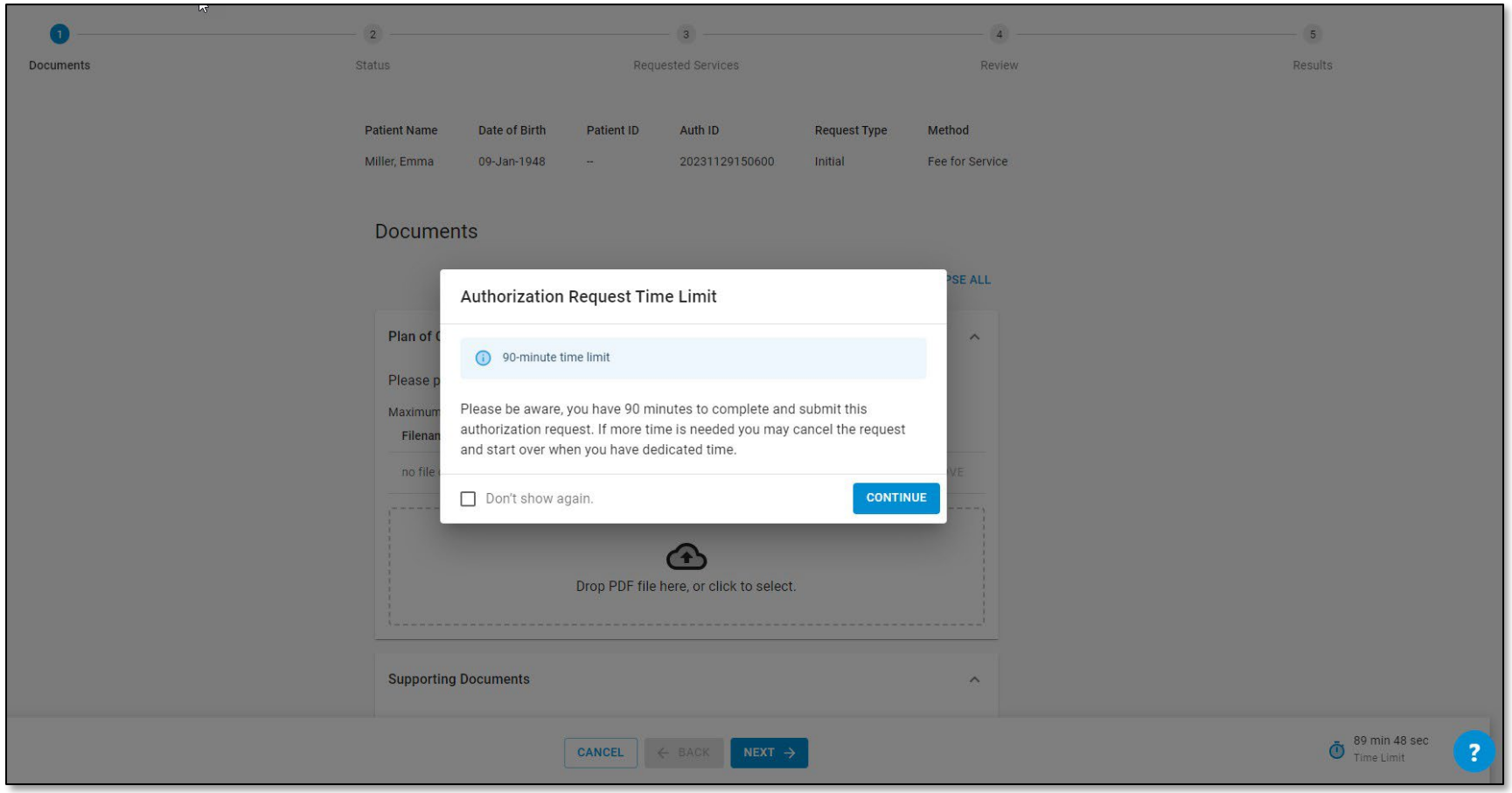
You will be automatically logged out of the Predictal Auth Automation Hub and taken directly to Helion Arc.



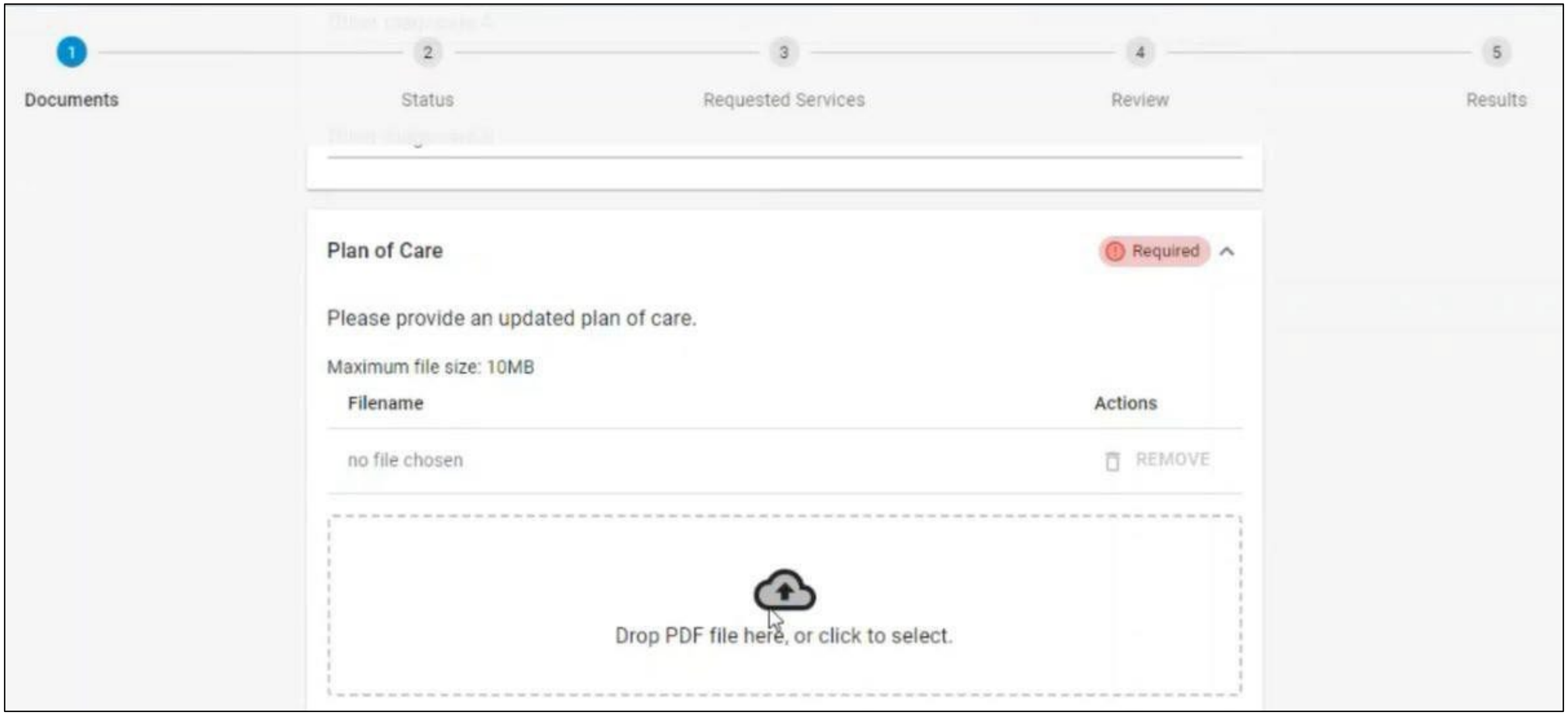
Once in Helion Arc, you will receive a message regarding the **Authorization Request Time Limit**, which indicates you have 90 minutes to complete and submit the authorization.

Click **Continue**.

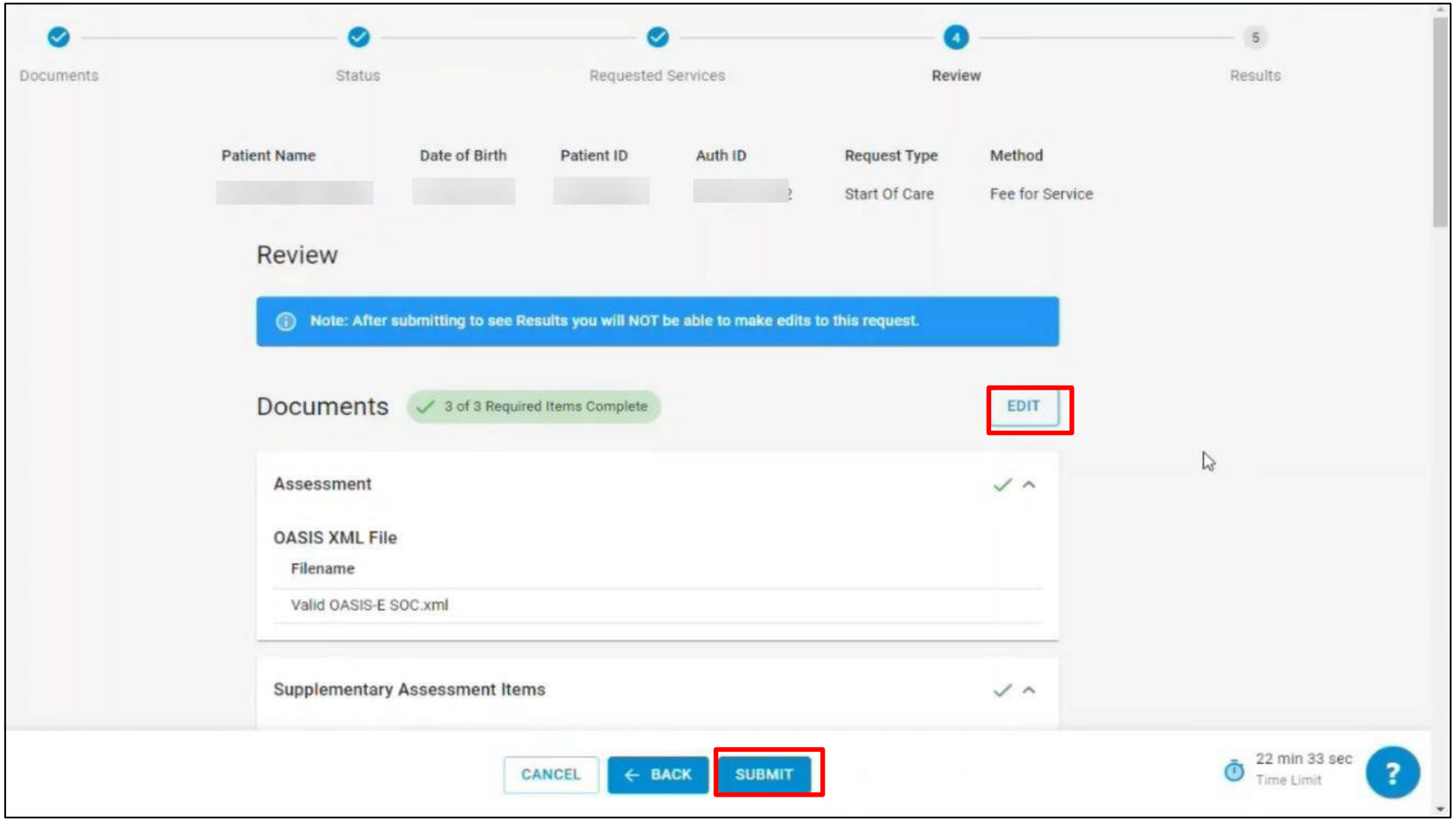
(Content may differ between requested services.)



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



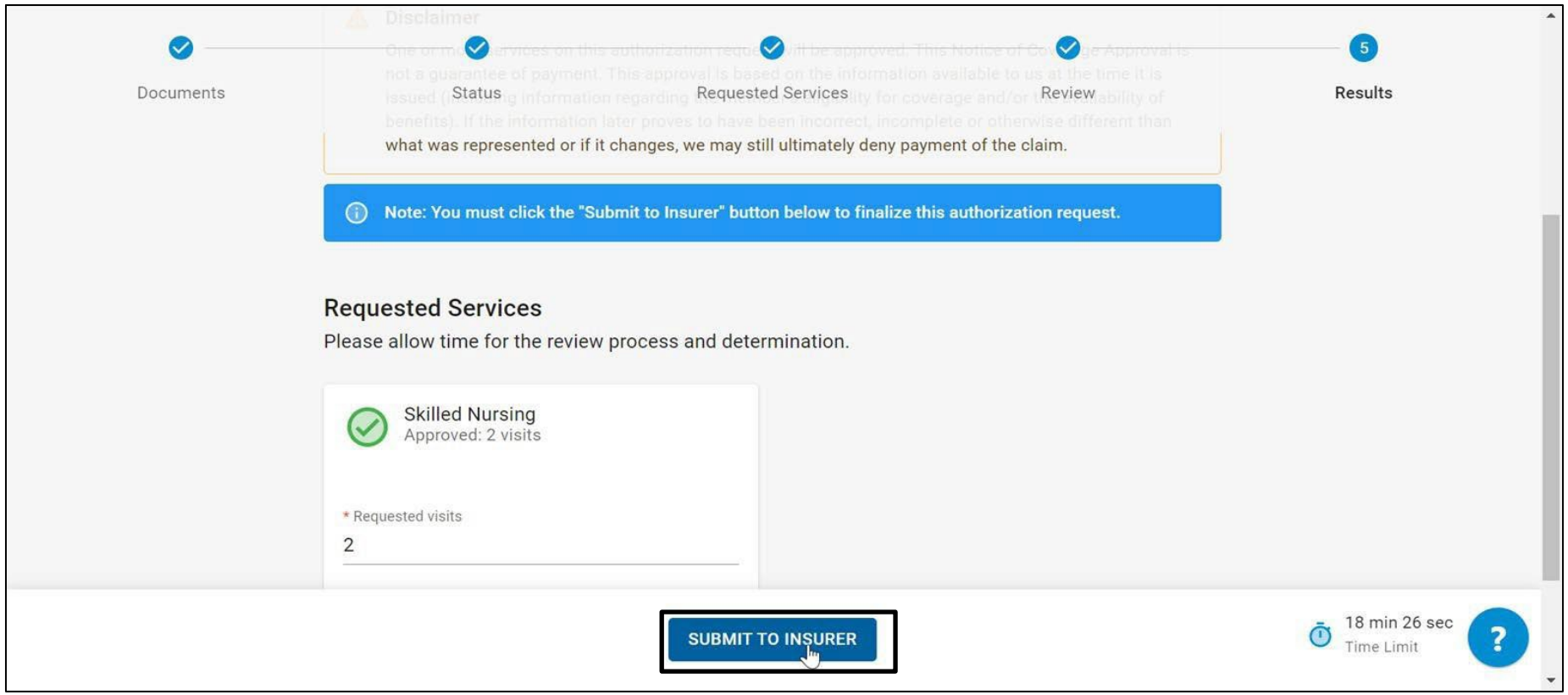
This is a review screen. You can edit any information using the **Edit** button located in each section. If all information looks correct, hit **Submit.**



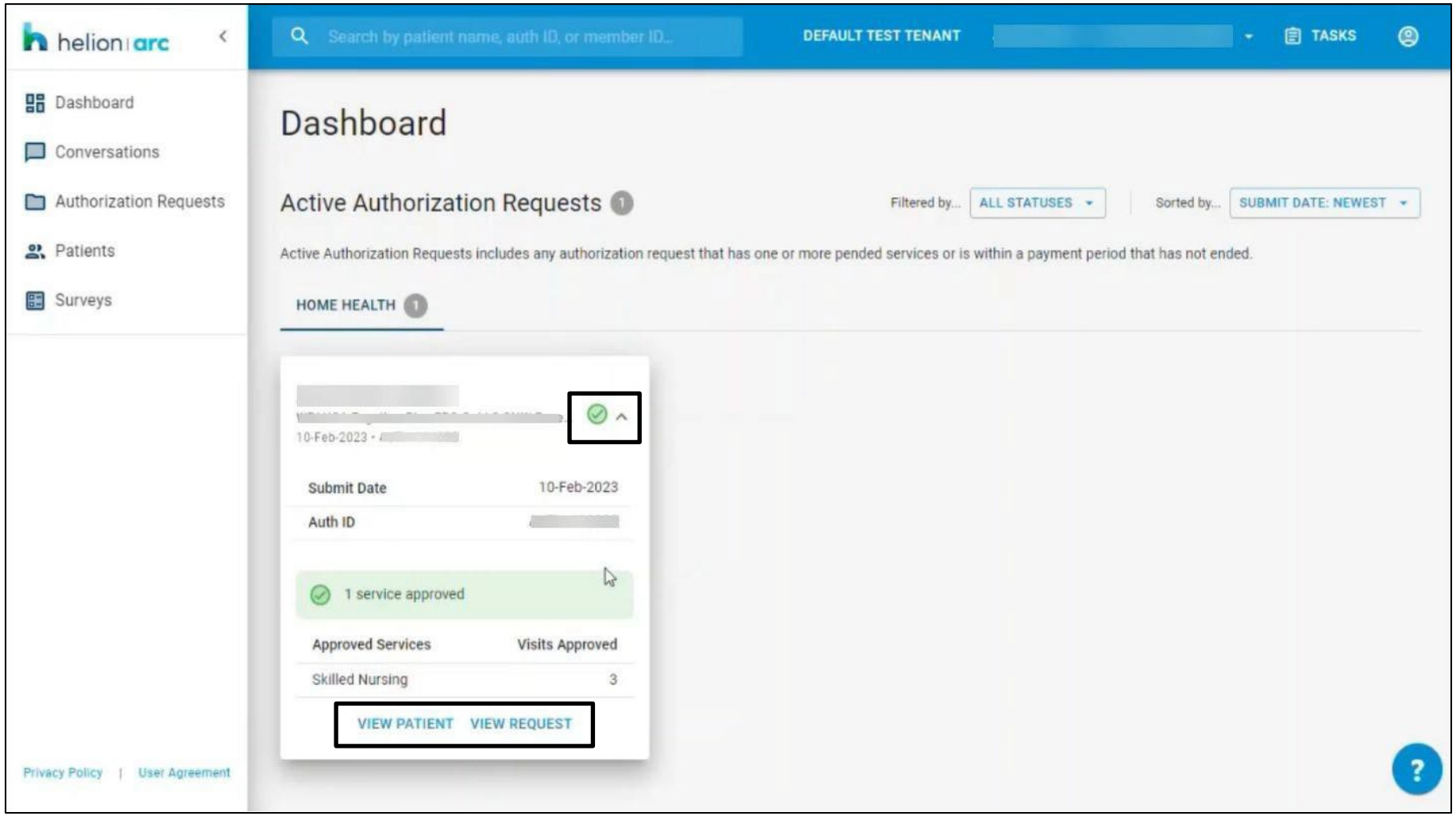
The request will be “Approved” or “Pended.”

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.”

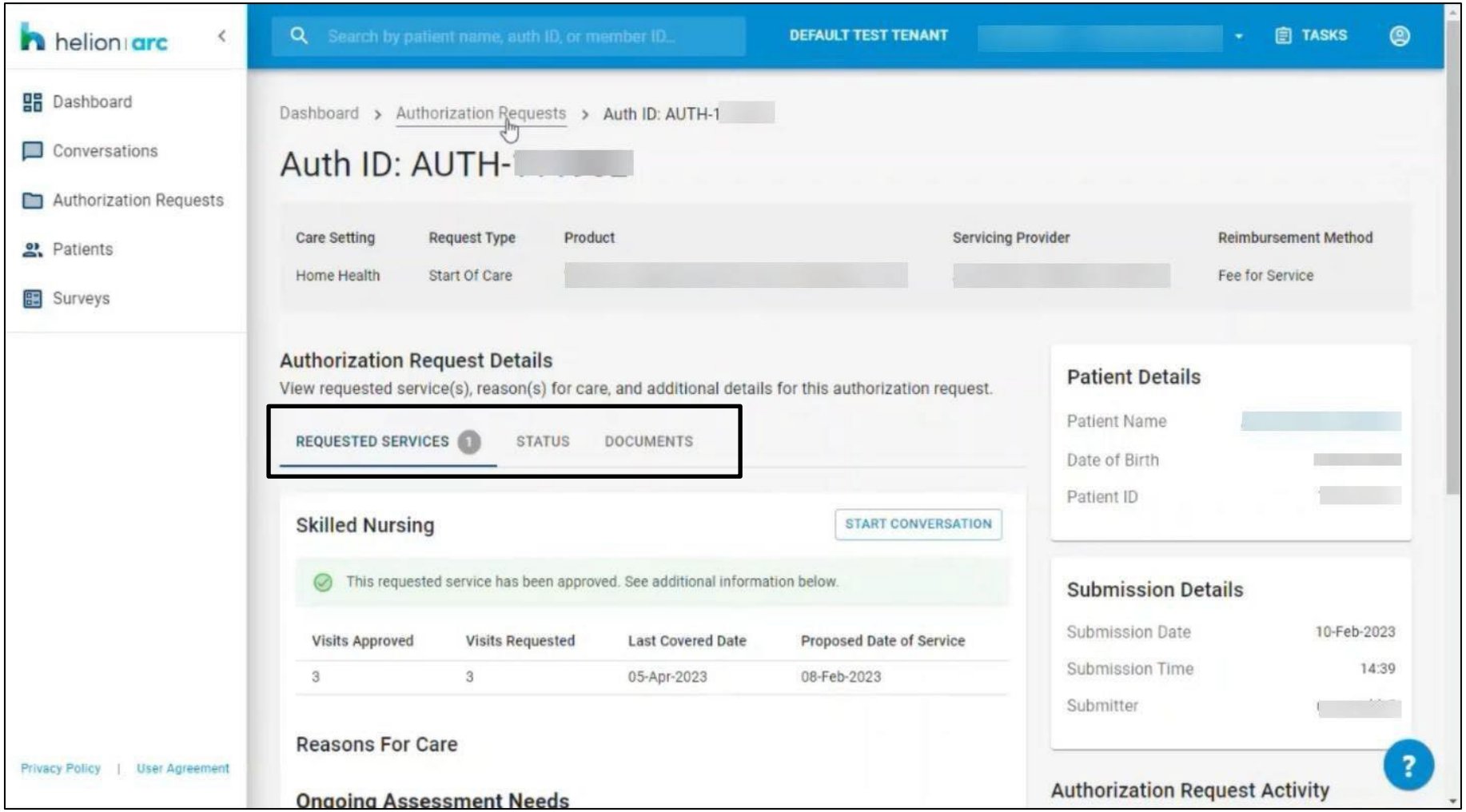


You will be directed to the Helion Arc dashboard, where you can view active authorization requests. Clicking the arrow will open the patient and request information.

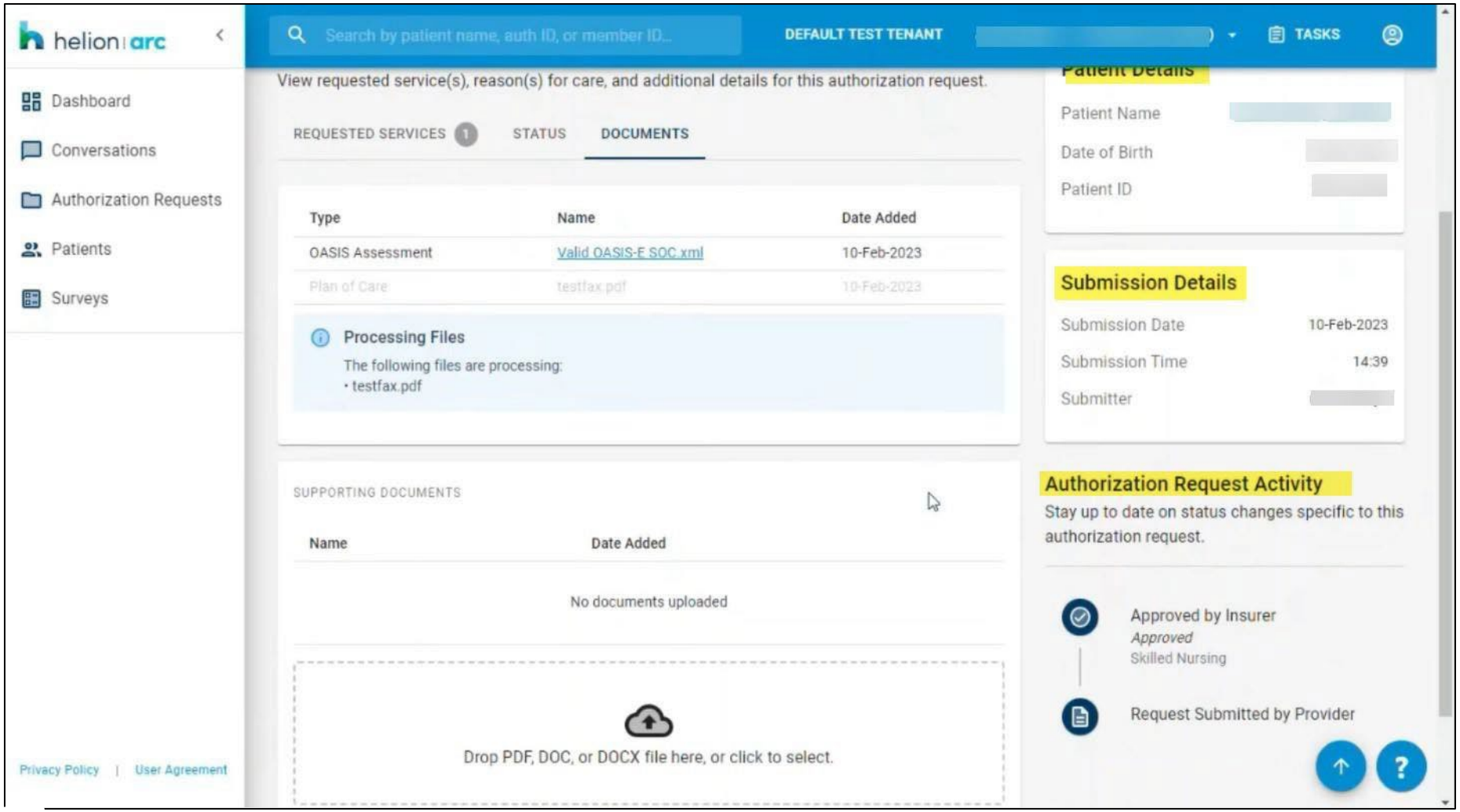


Clicking on either **View Patient** or **View Request** will open the **Authorization Request Details**.

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

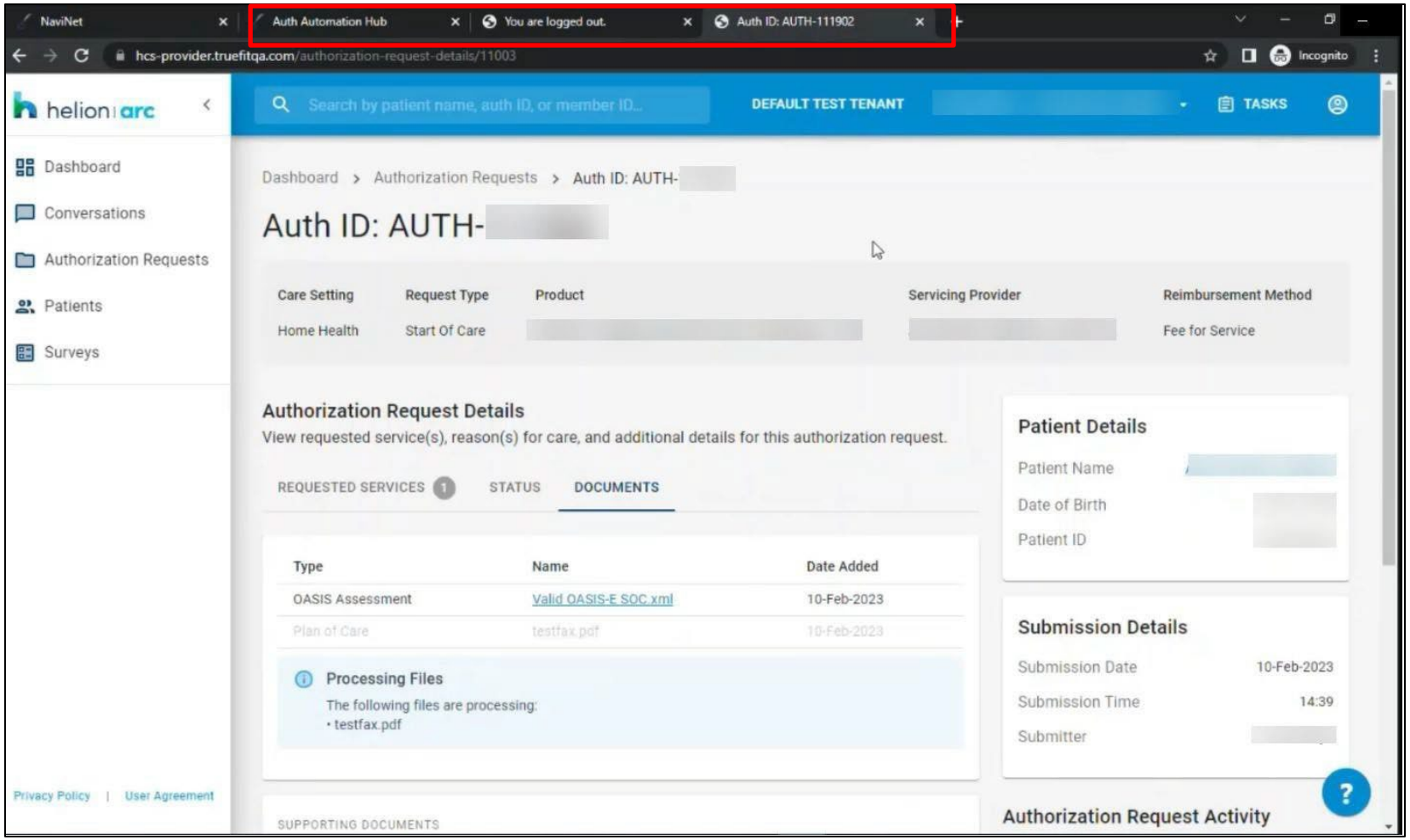


The panels on the right-hand side of the screen show you Patient Details, Submission Details, and an audit history under ‘Authorization Request Activity’



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

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

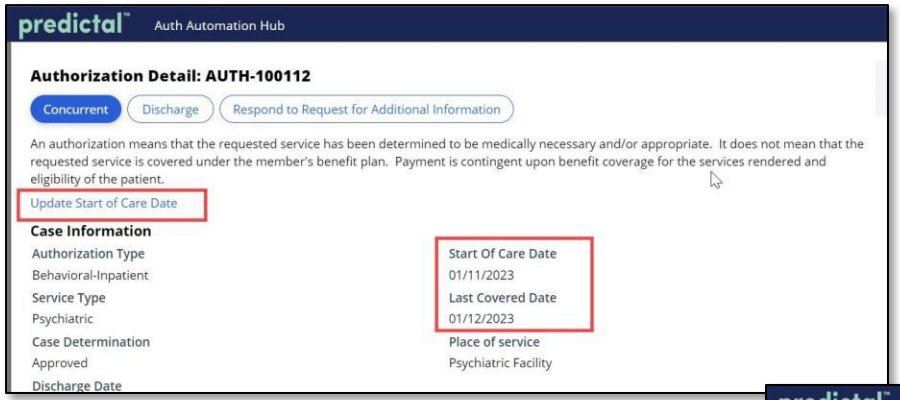


Availity Provider Portal - Predictal Authorization Inquiry

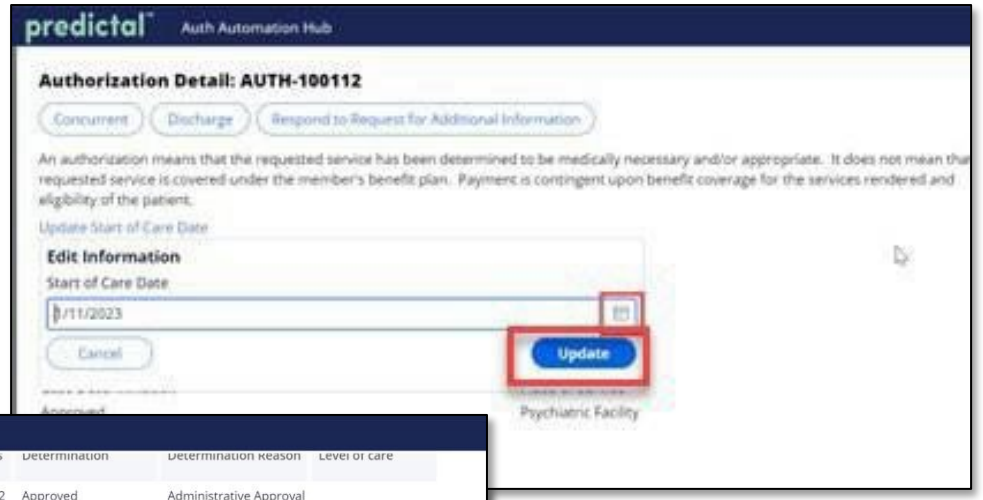
To update the Start of Care Date after the authorization is submitted:

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.

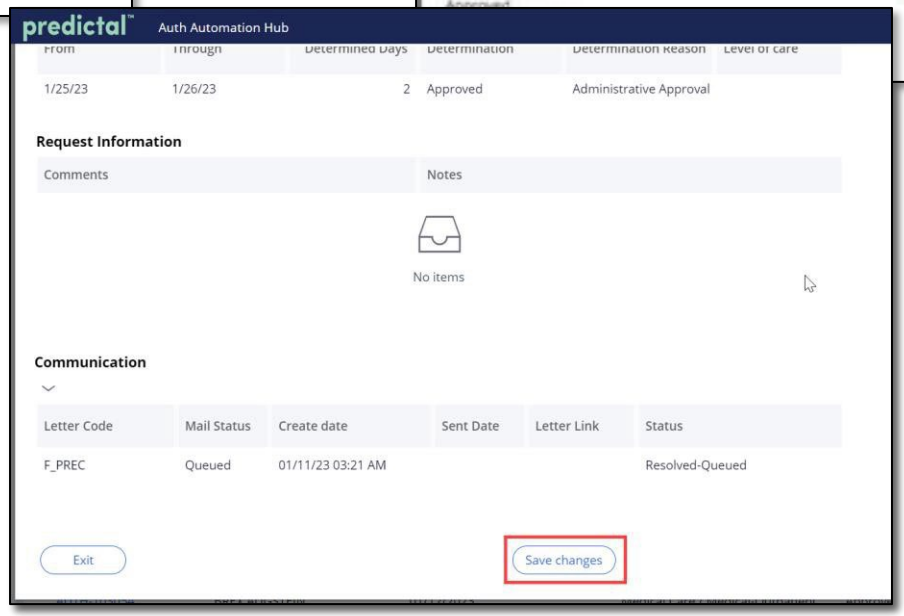
Step 1



Step 2



Step 3



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