Physical Medicine Management Program Changes – FAQs

March 2024

From Tivity to Helion Arc

Q1: Why is Highmark moving away from Tivity for Physical Medicine Utilization Management (UM)?

A1: Highmark is decommissioning Tivity® as a UM vendor, and moving to an insourced solution, Helion Arc. The change is effective **December 4, 2023**. We evaluated the advantages of our current UM Program and areas where we can innovate and improve. We looked closely at our opportunities and determined that an insourced solution provided better integration with Highmark systems, but also offered an enhanced UM experience for our providers.

Q2: What is Helion Arc?

A2: Helion Arc is integrated with the Predictal™ Utilization Management (UM) tool and enables offices to submit, update, and query medical authorization requests.

The application supports the management of members' care from end-to-end — including submission, case review and decision-support, and prescribed treatment programs. The move to Helion Arc is the result of Highmark's long-term commitment to enhancing the overall provider experience.

Q3: When will the change occur?

A3: The shift from Tivity to the Helion Arc was effective on **December 4, 2023**. While this does represent a change in the way that providers request prior authorizations for physical medicine services, the goal is to minimize provider disruption and ensure that the transition to Helion Arc is as seamless as possible. Aside from some minor differences in the user interface design, the overall process will remain very similar.

Q4: Will I have to resubmit an authorization request that was already submitted to Tivity?

A4: Authorization requests submitted prior to December 4, 2023, will be processed by Tivity. New Authorization requests **on or after** December 4, 2023, will process through Helion Arc. Tivity-approved requests will not need to be re-submitted to Highmark.

Submissions and Authorizations

Q1: Where do I go to submit an authorization request?

A1: The Electronic Authorization (eAuth) process starts in **Availity**. Go to **Payer Spaces** for the applicable Highmark region and then select **Predictal** from the Applications tab. For information on Availity, please visit your region's Provider Resource Center.

Q2: What is the difference between an Initial Request versus an Extension Request?

A2: The Electronic Authorization (eAuth) process starts in Availity and continues in the Helion Arc Technology Platform. To submit an initial authorization starting in Availity:

- Choose your state.
- Click **Payer Spaces** in the navigation bar.
- Select the Highmark logo for your region.
- Go to the Applications tab and select **Predictal**.
- Once in Predictal, select **New Authorization**.

To request additional visits or an **extension** to the service date range for treatment of the same body part or diagnosis, please submit an extension request rather than submitting a new authorization. You should

ensure the Plan of Care is uploaded as well, and this documentation is a requirement in the Helion Arc portion of the workflow.

To submit an extension request electronically, please use following these steps starting in Availity:

- Choose your state.
- Click **Payer Spaces** in the navigation bar.
- Select the Highmark logo for your region.
- Go to the Applications tab and select **Predictal**.
- Using the left hand-navigation menu, click **Auth Inquiry**.
- Search for the authorization by member, date of service, or request ID (AUTH #).
- Select the authorization under **Case ID**.
- Once you have clicked inside the authorization, you will see **Extension** in the top left corner. Click **Extension** and you can proceed with your request.

Q3: What do I do if I am a chiropractor who utilizes Physical Medicine codes?

A3: In Availity, go to **Payer Spaces** and click the **Predictal** tile. Once there, you will select **Chiropractic** under **Sub-Service Type**.

Q4: Do we need to submit a prior authorization for each discipline if a patient requires multiple services?

A4: A separate authorization is required for each profession delivering care. For example, a physical therapist will need a separate authorization from an occupational therapist, chiropractor, or speech therapist. (Please see Q5 and A5 for additional information.)

Q5: Do we need to submit separate prior authorizations if an OT or Chiro would like to bill for a PT procedure code?

A5: No, within Predictal under the **Procedure Information** section, you will select the primary discipline treating the patient. Click the box that states **Primary Discipline**. Click **ADD**, then select from the drop-down **Physical Medicine** if you would like to utilize these procedure codes.

- EXAMPLE: If you are a Chiro, the first sub service type you choose is Chiro and click the **Primary Discipline for Treatment** box, then **ADD** another sub service type for **Physical Medicine**, but do **not** select the primary box. Please check that the specific procedure code that you are billing for falls within that discipline's sub service type description. **NOTE:** Descriptions are listed under each sub service type. If the procedure code is not listed, cancel and then **ADD** the other sub service type, checking that the procedure code falls within that discipline's code description.

Q6: What do we choose under Service Type after we have selected our "Place of Service"?

A6: For all outpatient clinics/offices, you must choose "Rehabilitation" as your Service Type to be able to complete the Procedure Information that should consist of dropdowns for PT, OT, Chiro, and ST with the procedure codes that are associated with that discipline.

Helion Arc

Q1: Do I need to request access to Helion Arc to submit an authorization request?

A1: At this time, electronic authorization submissions can be processed within the Helion Arc Technology Platform through a seamless transition that does not require direct access or login.

You will be redirected to Helion Arc per the electronic authorization process through Availity and the Predictal Auth Automation Hub. Providers who require access to a Helion program and/or access to performance analytics and scorecards will still be required to login. Please submit a ticket if you are unsure and we will assist. Here's the link to the Helion Service Desk: https://helionhc.atlassian.net/servicedesk/customer/portal/2

Q2: How many visits would be eligible for approval?

A2: Visit amounts will vary based on provider performance and responses submitted within Helion Arc each calendar year.

Q3: Can I agree with or change the approved number of visits for an authorization request submitted within Helion Arc?

A3: As of **February 14, 2024**, physical therapists, occupational therapists, and chiropractors will not have the ability to request more than the visit amount for initial and extension requests. Providers are required to submit an extension request for prior authorization once they have used the visits provided from the initial request. This enhancement supports Helion's data driven approach to ensure delivery of medically necessary high-quality care.

Q4: Does Helion Arc require Plan of Care?

A4: Helion Arc does not require the Plan of Care for initial authorization requests, but does require a Plan of Care for **extension requests**.

Q5: Can you submit multiple diagnosis codes?

A5: You need to submit the diagnosis code(s) that are pertinent to your Plan of Care for the patient.

Q6: Why do we only have 90 minutes to complete the information within Helion Arc and what happens if we do not complete within that timeframe?

A6: The 90-minute timeframe is set up that way to mitigate potential exposure of member information on the screen for too long. If you do not complete within the 90-minute timeframe, your information will be lost and you will need to start over.

Provider Pathways Program Update

Q1: What will happen to my Provider Pathways Program status?

A1: Providers who were awarded Pathways status based on 2023 performance will be included in the **Helion Arc High-Performance Provider** (HPP) list, which is replacing the Provider Pathways Program for 2024.

Q2: How many visits would be eligible for approval?

A2: Visit amounts vary based on provider performance, visit totals, type of request, and clinical information provided via the authorization submission process. Providers may request additional visits by submitting for an extension request.

Qualifying High-Performance Providers (HPP) will experience a greater level of self-management than non-High-Performance Providers when it comes to obtaining authorizations. Providers will experience near real-time determinations and be eligible for automated approvals up to 20 visits for a member when submitting electronically via Availity. For requests that have "pended" to Highmark Utilization Management for a secondary medical necessity review, please provide specific clinical information upon request to ensure a faster response.

Retrospective Reviews, Appeals, and Peer-to-Peer Requests

Q1: Will providers still be able to submit retrospective review requests?

A1: For retrospective review requests submitted **on or after** December 4, 2023, providers are encouraged to utilize the Provider Portal (Availity). If the request falls outside of the Provider Portal acceptance threshold, providers can contact Utilization Management at 1-800-452-8507.

After 30 days from the start of care, send requests to the Highmark Medical Review team. Retrospective review requests should be sent to following address:

Medical Review
PO Box 890392
Camp Hill, PA 17089-0392

Q2: Will appeals for denied visits be managed in a different manner?

A2: Today, all Medicare Advantage appeals are managed through Highmark Medical Review, with direction on where/how to submit appeals included in the denial statement. That process will not change with the conversion to Helion Arc.

Commercial appeals for denials on requests submitted **on or after** December 4, 2023, will be reviewed by the Highmark Medical Review team. Directions on where/how to submit appeal requests will be included in the denial statement.

Additional information on appeals can be found in the *Highmark Provider Manual*, Chapter 5, Unit 5.

Q3: Will providers still be able to request Peer-to-Peer evaluations?

A3: Yes. To initiate a Peer-to-Peer request **on or after** December 4, 2023, providers should call the dedicated, peer-to-peer phone number: 866-634-6468. Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday.

Q4: How will providers initiate date changes, extensions, or obtain answers to other Utilization Management questions?

A4: Utilization Management requests submitted **on or after** December 4, 2023, should be directed to the Highmark Utilization Management Team number: 800-452-8507.