Highmark Provider Portal FAQs:
Authorization Process via Availity Essentials®

February 2026

General Authorization Process Changes

Q1: What is the primary change to the authorization request process for Highmark members (including Federal Employee Program [FEP] members)?

A1: All initial authorization requests for Highmark members (including FEP members) must now be started in Availity Essentials.

Q2: Do these changes apply to all types of authorizations (initial, extensions, concurrents, etc.)?

A2: This new process primarily applies to **initial authorization requests**. Extensions and concurrent requests will continue to be submitted through Predictal via Payer Spaces.

Q3: If I started an authorization request in Availity, will I be able to see its status or return to complete it later?

A3: Yes, the **Availity Essentials Multi-Payer Authorization Dashboard** will display authorizations that were initiated within Availity. Users can begin an authorization and return later to complete it via the dashboard.

Q4: What if I have existing authorizations that were NOT entered via Availity?

A4: For inquiries on authorizations <u>not</u> entered via Availity, or for existing authorizations, you will need to go to Predictal via Payer Spaces. Existing authorizations submitted prior to this change will still be honored.

Q5: What if I currently use Predictal for authorizations today?

A5: If you currently use Predictal for initial authorizations, they are now being handled by this new Availity Essentials workflow. For authorizations that will continue to be submitted directly in Predictal (such as extensions or concurrents), you will continue to use your current process.

Q6: Will there be training materials available for this new process?

A6: Yes, training materials are available on Availity. You can access the recorded webinar and handouts from the Availity Learning Center. Select **Help & Training** from the top of Availity Essentials, then select **Get Trained**, and search for "Highmark." Handouts were also shared during the webinar; if you couldn't access them, you can request them by emailing training@availity.com and including the webinar title and date. *If you cannot open a PDF or access a handout, please email training@availity.com or contact Availity Client Services.*

Q7: Is there a "save" option if I need to pause while submitting an authorization?

A7: The system remembers previously entered information for initial authorizations. You can begin an authorization in Availity and return to complete it later via the Multi-Payer Authorization Dashboard.

Q8: Why are my Highmark authorizations <u>not</u> showing in the Availity Dashboard?

A8: The dashboard in Availity is only going to show authorizations submitted using the Availity Essentials workflow. If you are following this process, they should appear.

Workflow Details

Q1: How do I submit an initial authorization request through Availity Essentials?

A1: You will start the authorization request directly within Availity Essentials. The system will guide you through entering member, provider, and service information. If the service is managed by Highmark or other delegated entities, the system will then single sign-on (SSO) you to Predictal to complete the authorization.

Q2: What if I am taken to Predictal from Availity? Will I be able to upload documents or clinicals there?

A2: Yes, if the system routes you to Predictal (the Predictal Auth Automation Hub), you will have the option to add documentation and upload clinical documents to support your request. All information entered in Availity Essentials will be pre-populated in Predictal.

Q3: Will procedure codes be required for all authorization requests?

A3: Procedure codes <u>are required</u> for outpatient submissions. For inpatient authorizations, procedure codes are <u>**not**</u> required fields. You can add up to 12 procedure codes to a single request.

Q4: What is the process for Chiropractic, Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) authorizations?

A4: For initial Chiro, PT, OT, and ST authorizations, enter a single CPT code for the service in Availity Essentials. (Only one CPT code is needed at this initial step.) If an authorization is required, the system will then prompt you to Single Sign-On (SSO) to Predictal.

In Predictal, the relevant sub-services and their associated procedure codes will be prepopulated directly from Availity Essentials. You can then add any additional sub-services that apply to complete the authorization.

Q5: How do I submit an authorization for multiple disciplines (e.g., PT, OT, ST) for the same patient?

A5: You will follow the same process, starting in Availity Essentials. The system will guide you through the submission for each discipline, potentially using a single sign-on to Predictal where you can add additional sub-services for each therapy type.

Q6: How do I check the status of an authorization or review approval/denial letters?

A6: Authorization Inquiry functionality is available through Predictal via Payer Spaces. You can use this to check authorization status, review approval and denial letters, and handle discharges or concurrent requests. Authorizations initiated in Availity Essentials can also be viewed on the Multi-Payer Authorization Dashboard.

Q7: When submitting an authorization, should I select the ordering provider or the servicing provider?

A7: When selecting the requesting provider, choose "Facility" if you are a facility. If the ordering and servicing practitioner are the same, select "Both" if available, or choose the ordering provider. For outpatient physical therapy, the requesting provider should typically be the ordering provider. If you work for both servicing and ordering providers, the system should allow you to pick either. The system allows you to select both group and individual providers.

Case Types and Timeframes

Q1: What are the different "Case Types" for authorizations?

A1: When submitting a request, you will select from:

- **Prior Authorization:** Services have not yet been rendered. “Start of Care” is the date you submit the authorization, or the future date when services will begin.
- **Retrospective Pre-Claim Review:** Services have been rendered, but a claim has not been submitted. Submit within 30 days of the “Start of Care” date
- **Retrospective Claim Review:** Services have been rendered, and the claim was denied.

Q2: How long will the authorization be good for?
A2: Once reviewed, the date span will be included.

Gold Carding Program

Q1: What is the "Gold Carding Program" and how does it affect authorizations?
A1: The Gold Carding Program provides certain providers with approved procedures based on the member's group information, benefits, and service type. The Authorization Request form in Availity Essentials will indicate if the service is gold card-approved. If approved, you must scroll down and hit “Submit” to finalize the request. Information on this program is available via the Provider Resource Center.

Out-Of-Area (OOA) Members

Q1: What if I need to submit an authorization for an OOA member?

A1: If you are requesting an authorization for an OOA member, you will start your authorization in Availity Essentials under **Patient Registration** and then **Payer**. If Highmark is not listed, select “Other Blues” to proceed. The system will identify that the prefix belongs to another plan and will direct you accordingly. For FEP members, please use the “R” number in the member ID field.

Vendors

Q1: Will I still use eviCore or Home & Community Care Transitions for certain authorizations?
A1: Yes, see below.

eviCore:
For eviCore authorizations, the process remains unchanged, and you will continue to use eviCore as needed. Predictal will guide you to the next steps in the authorization process if an authorization requires routing to a delegated entity.

Home & Community Care Transitions:
Home & Community Care Transitions will manage care coordination for Medicare Advantage authorizations received **prior to Feb. 28, 2026**, at 11:59 p.m. ET, until the member's discharge or care coordination is no longer medically necessary. **For authorizations received on or after March 1, 2026**, at 12 a.m. ET, Highmark will be responsible for all associated care coordination needs. You will need to submit all new initial authorizations through Availity Essentials, which will then route you to Predictal, and subsequently to the Helion Arc Technology platform for processing.

Auth AI Workflow

Q1: What if my authorization request takes me into the "Auth AI" workflow?
A1: If your request qualifies for the Auth AI workflow, you will be directed to an “Add Attachments” screen. You will upload clinical documentation (up to 10 files in image, document, or PDF format). Auth AI will then

process this documentation to identify clinical questions and pre-populate answers. You will review and modify these answers as needed, then complete certifications and submit.

Eligibility & Benefits (E&B) Verification

Q1: How important is it to verify Eligibility & Benefits (E&B) before submitting an authorization?

A1: It is critical to check the member's E&B in Availity Essentials before submitting a prior authorization. This helps to:

- Avoid submitting unnecessary authorization requests.
- Confirm patient copays and/or coinsurance.
- Minimize claims rejections. To do this, go to **Patient Registration** > **Eligibility and Benefits Inquiry** in Availity.
- *If you receive an error like “Member ID# pending” or “Member ID is not valid” when checking eligibility, it could mean the payer is updating the patient's membership. Try resubmitting the Eligibility and Benefits Inquiry later or contact the payer for more information. If the member ID does not exist but you know it's correct, create a trouble ticket.*

Troubleshooting and Support

Q1: What if I experience an error when submitting an authorization?

A1: If you receive an error when submitting, contact Availity Customer Service (800-282-4548 M-F 8 a.m. – 8 p.m. ET). Availity will submit a ticket to a team that will work with you on the issue. For Predictal-related issues, contact UM at 800-452-8507 to report the issue, get assistance with your case, and then a ticket will be submitted to the Provider Digital Support team to work through the issue with you.

Q2: My web browser seems to be having issues with Availity. What should I do?

A2: For the best experience, use Google Chrome. If you encounter issues, try clearing your browser's cache and cookies. This can resolve loading or formatting problems. Instructions for clearing cache are available in the training materials. *If you are experiencing a “black screen” when trying to access Availity, try exiting and rejoining.*

Q3: What if an out-of-state requesting facility "can't find" the patient or provider in Availity?

A3: If you are from an out-of-state requesting facility and Availity cannot find the necessary information, please contact Availity Client Services for assistance. If you are missing a state in the dropdown section, please contact your Availity administrator to have it added.

Q4: What if I need to change a CPT code or a facility NPI on an existing authorization?

A4: To change a CPT code after an approval, or to change a facility NPI on an authorization, you can call UM at 800-452-8507 to request the change.

Q5: How do we request additional visits for therapy?

A5: Requesting additional visits for therapy should be handled as an extension through Predictal via Payer Spaces.

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