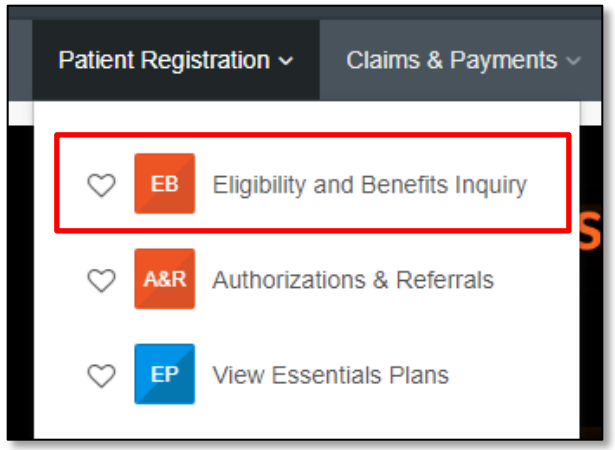
Availity® Provider Portal
Outpatient Authorization Submissions

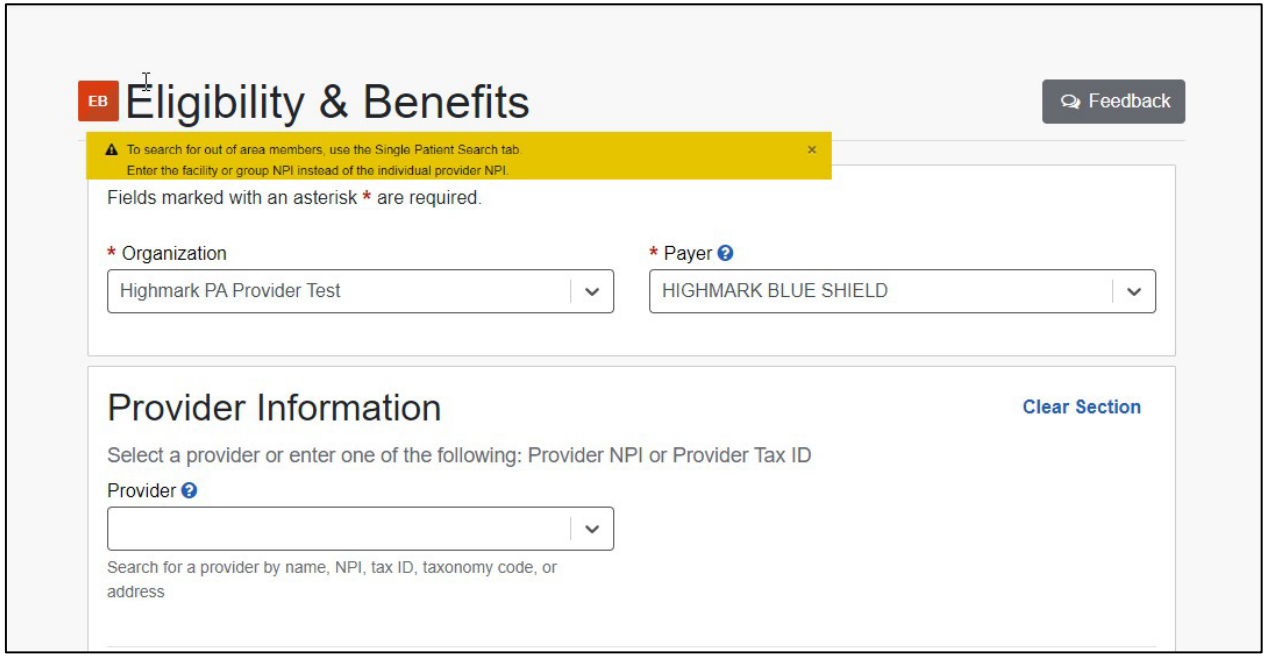
Before beginning use of the Availity application, users should make sure that their browser is **Chrome**.

Note: *If users are experiencing unexpected errors with functionality, reboot or consider checking to see if the cache has been cleared.*

Prior to submitting a prior authorization request, users 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** on the main menu bar and click on **Eligibility and Benefits Inquiry**. Complete the form, including Provider, Member and Service Information.

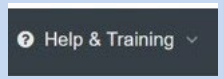




*Verifying Eligibility and Benefits prior to submitting a prior authorization request and/or submitting a claim can:

1) Help users 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.

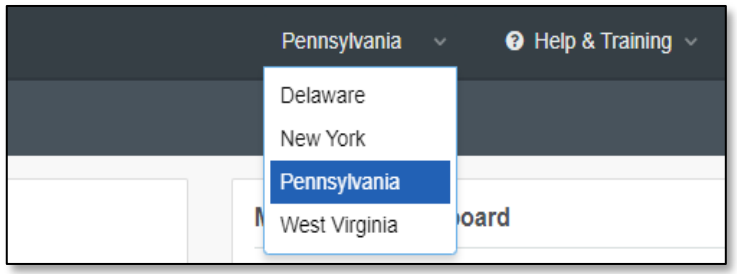


Submitting Prior Authorization Requests

Also, refer to:
https://providers.highmark.com/claims-and-authorization/authorization-guidance/obtaining-authorizations
on the Provider Resource Center (PRC).

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

After logging into Availity, first choose the appropriate state for the practice or facility. *(Required for Path 1, but not for Path 2.)*



Next, choose the authorization path:

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

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

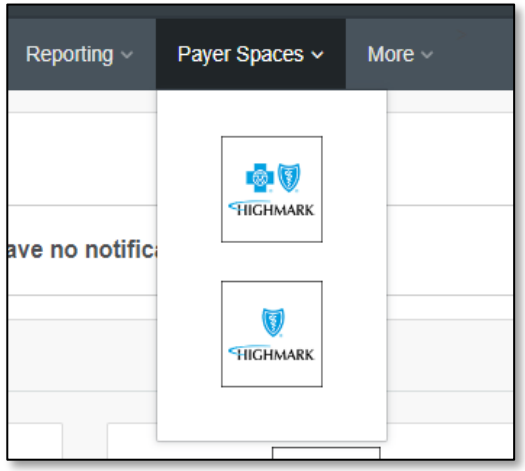
Exception 1:
Retail Pharmacy Authorization Submissions
Can ONLY Use Path 1

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

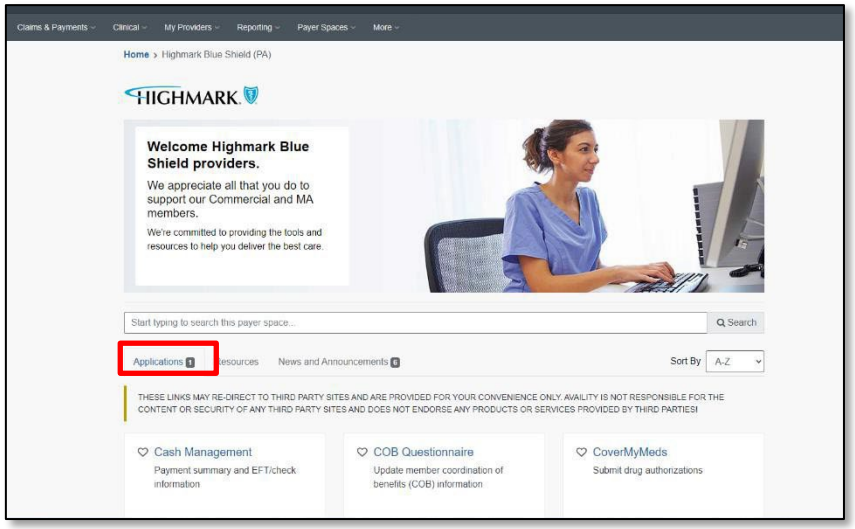
Path 1

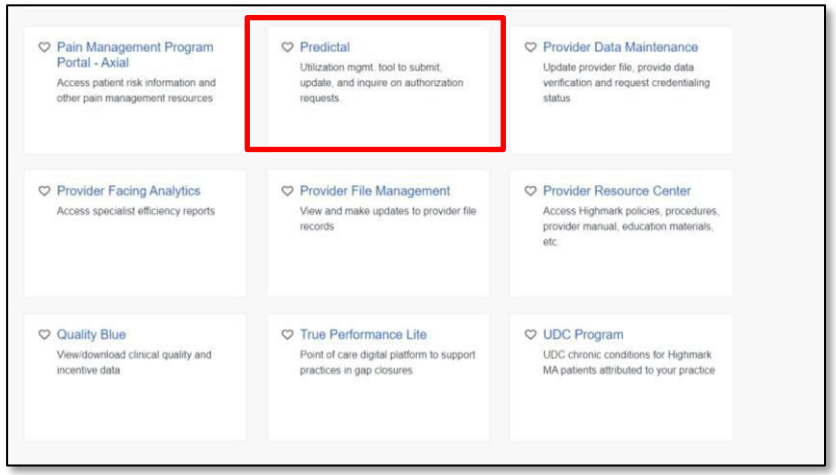
To access Highmark's Payer Spaces in Availity Essentials, click on **Payer Spaces** from the top menu and choose the appropriate Health Plan.

Note: For prior authorization requests for Retail Pharmacy, Path 1 must be used for submissions. To check an Authorization Status and/or submit an Authorization Inquiry, Path 1 must be used to access Predictal via **Payer Spaces**.



Within **Payer Spaces**, look under **Applications**, scroll down, and select the **Predictal** tile.





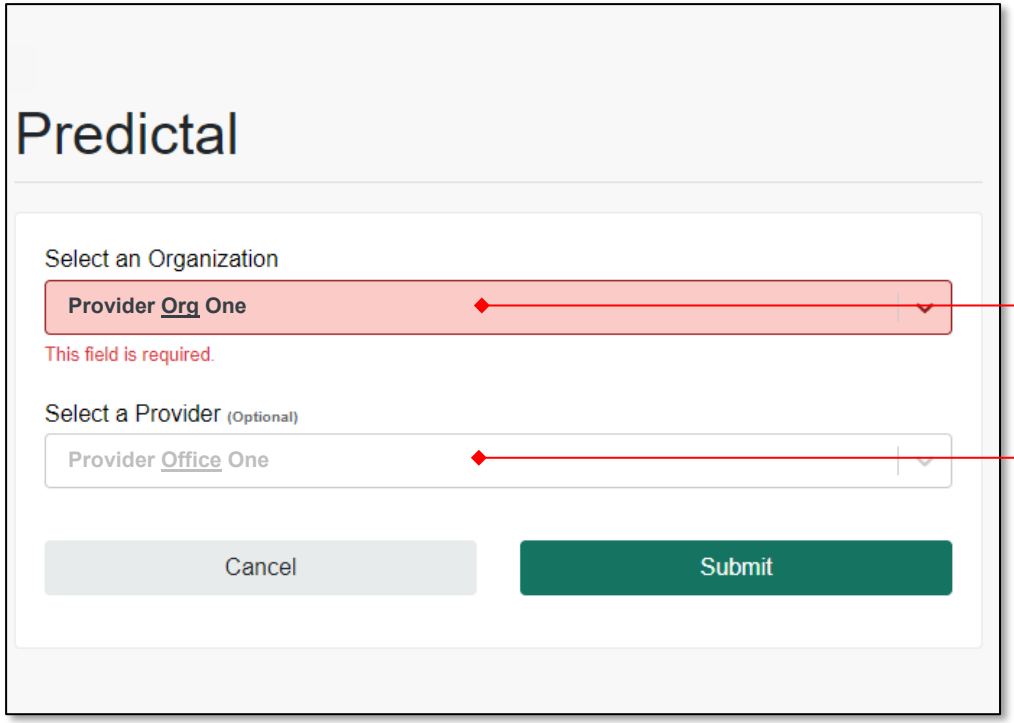
Path 1

Once users have selected Predictal, they must choose the **Organization**.

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

That will take users into the Predictal Authorization Automation Hub (AAH) to complete the prior authorization request.

When the Predictal AAH opens in the next screen (or during the next step), users will then be prompted to select the **Submitting Provider** (the individual practitioner or provider requesting the authorization).



Also refer to this Provider registration resource on the new Provider Resource Center (PRC):
https://providers.highmark.com/latest-updates/availity/registration

NOTE:
If the Organization within Availity's Manage My Organization (MMO) only has one Tax ID, it is recommended to only **Select an Organization** to return more search results in the next step within Predictal's Authorization Automation Hub.

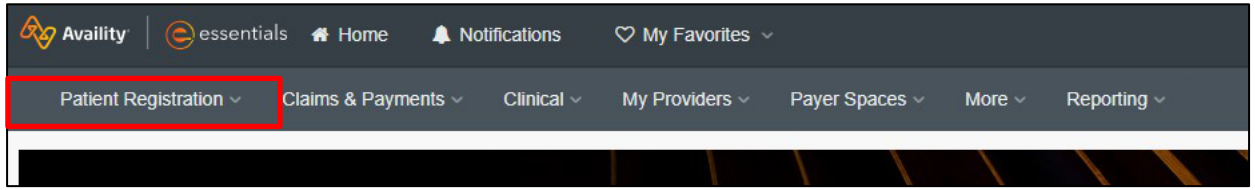
If users have multiple Tax IDs within the Organization within MMO, choose the Group (Type 2) NPI for the specific tax ID — NOT the individual Practitioner's (Type 1) NPI — in the **Select a Provider** drop-down menu.

- If you do not see your Group (Type 2) NPI in this list, or you chose a practioner (Type 1) NPI, you will not see the requesting provider properly in the Predictal AAH next step when beginning the authorization or it could result in a system error.
- Your Administrator would need to add the group as a provider under the Organization in **Manage My Organization** within Availity as referenced with the Highmark specific Manage My Organization Guide*.

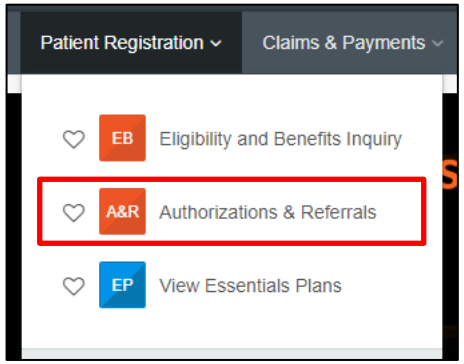
Path 2

To access **Authorization & Referrals**, first click on **Patient Registration** from the main menu at the top of the screen.

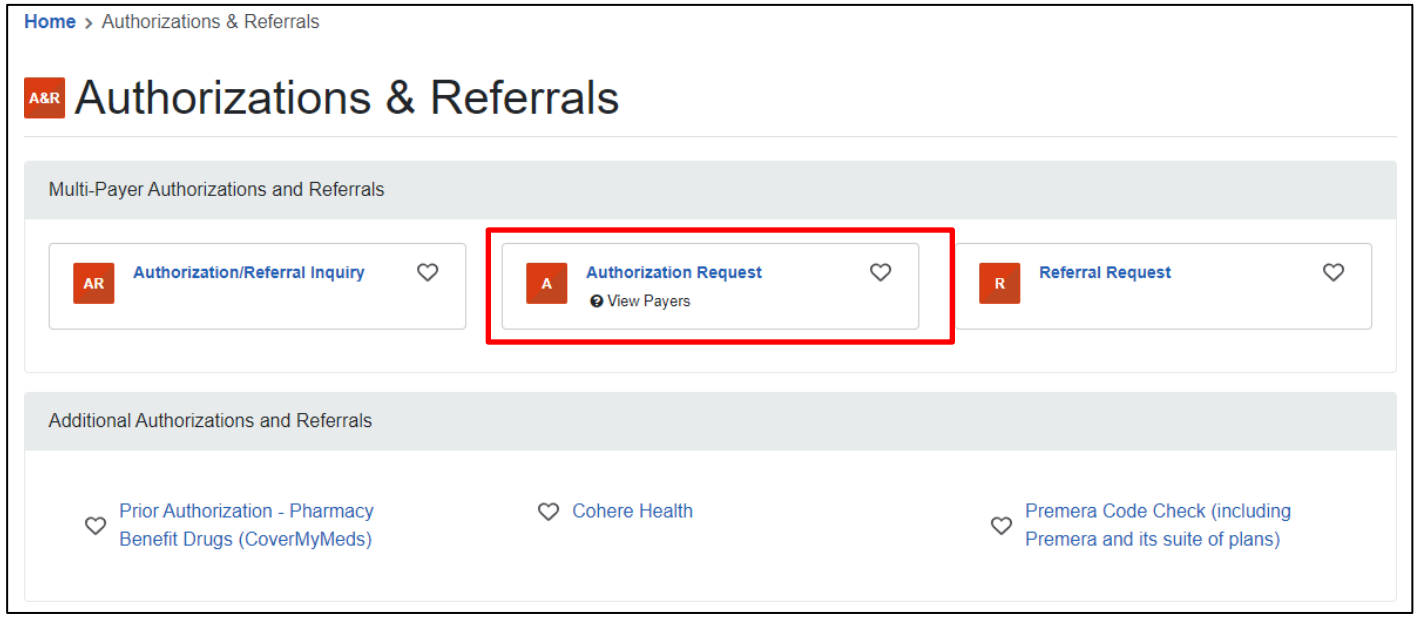
***For prior authorization requests for Out-of-Area providers, Path 2 must be used for submissions.**



Then select the **Authorizations & Referrals** option.

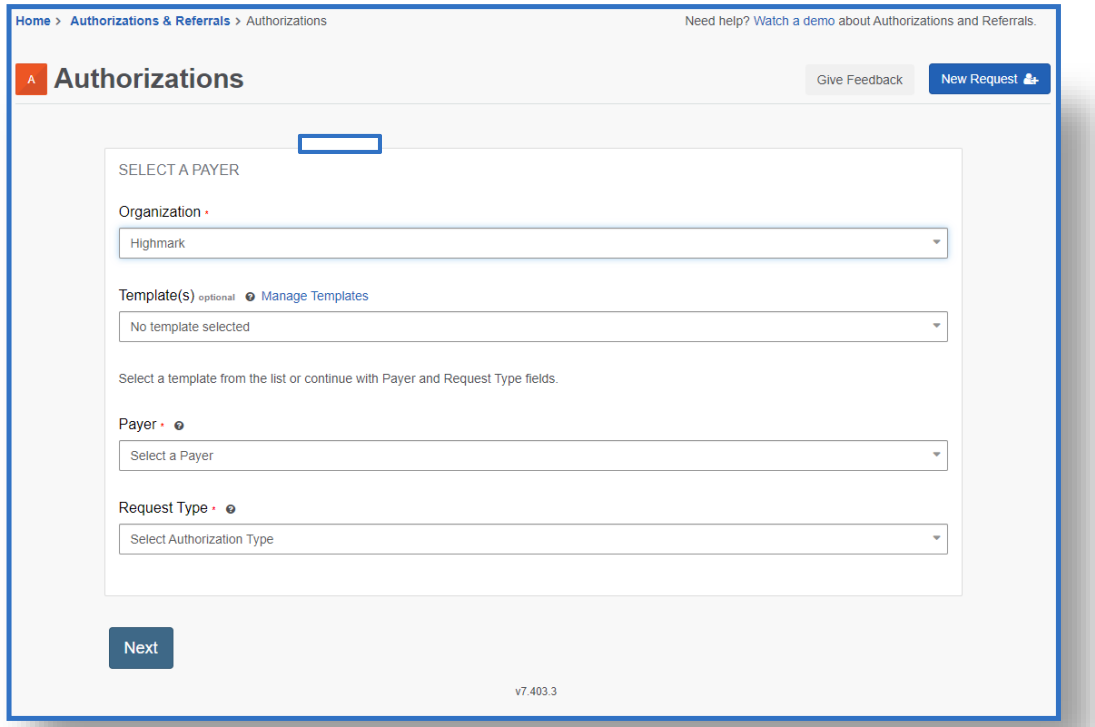


Next, select the **Authorization Request** option.

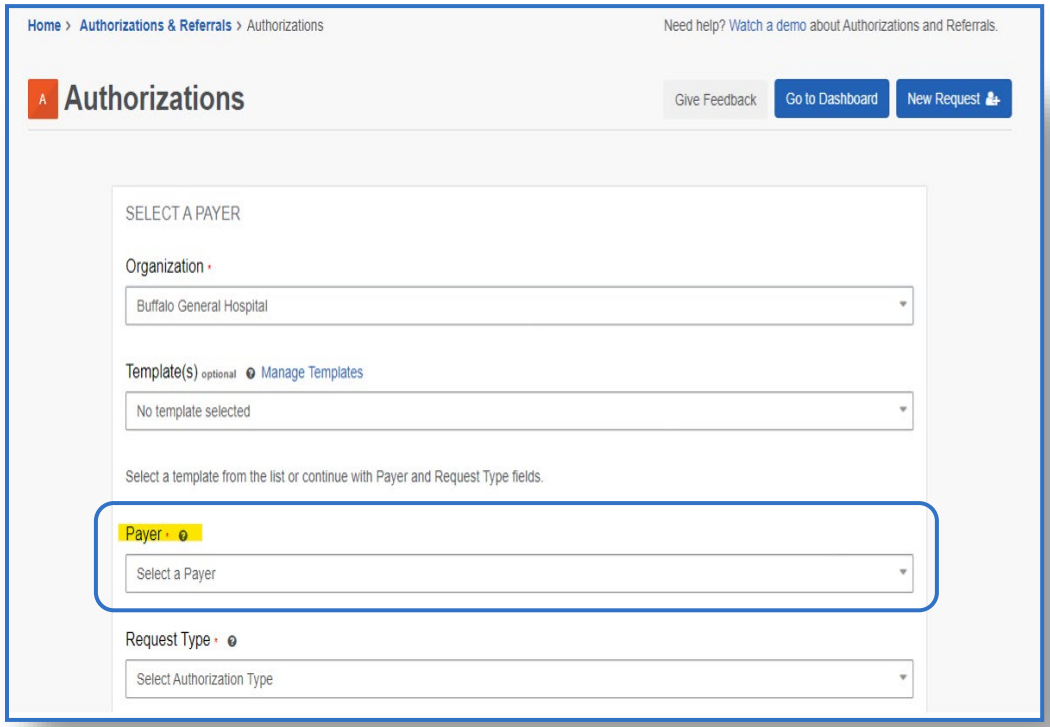


Path 2

Once the **Authorization Request** is selected, complete the form with the appropriate information. Additional fields will appear as the user completes the online form.



For Out-of-Area (OOA) providers to submit a request for a Highmark member, they need to use the path of **Patient Registration**, then under **Payer** — if Highmark is not listed — they must select **Other Blues** to proceed.



Path 2

First, **Select an Organization** — the tax ID that contains the Group (Type 2 NPI) — for the requesting provider**.** Select the **Payer** and **Request Type** and then click **Next**.

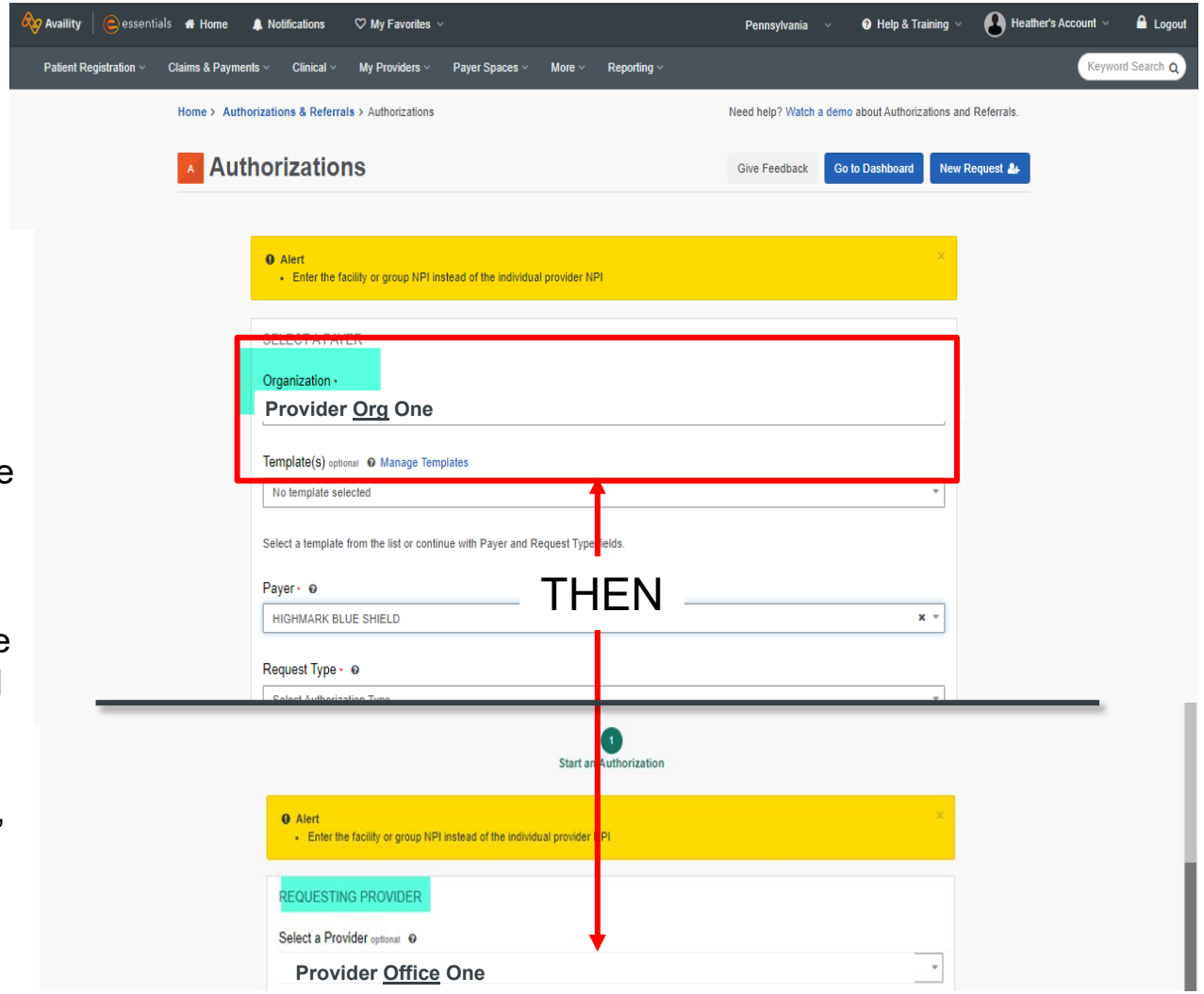
Then, under the Requesting Provider, **Select a Provider** dropdown, choose the Billing Group (Type 2) NPI for the specific tax ID but NOT the individual Practitioner (Type 1 NPI).

If the user does not see the Group (Type 2) NPI in this list, or the user erroneously chooses a practioner (Type 1) NPI, the user will not see the requesting provider properly in the Predictal AAH next step when beginning the authorization (or could result in a system error).

Your Administrator would need to add the group as a provider under the Organization in **Manage My Organization** within Availity as referenced in the Manage My Organization Guide*.

When Predictal/AAH opens in the next screen (or during the next step), users will be prompted to select the **Submitting Provider** (the individual practitioner or provider requesting the authorization).

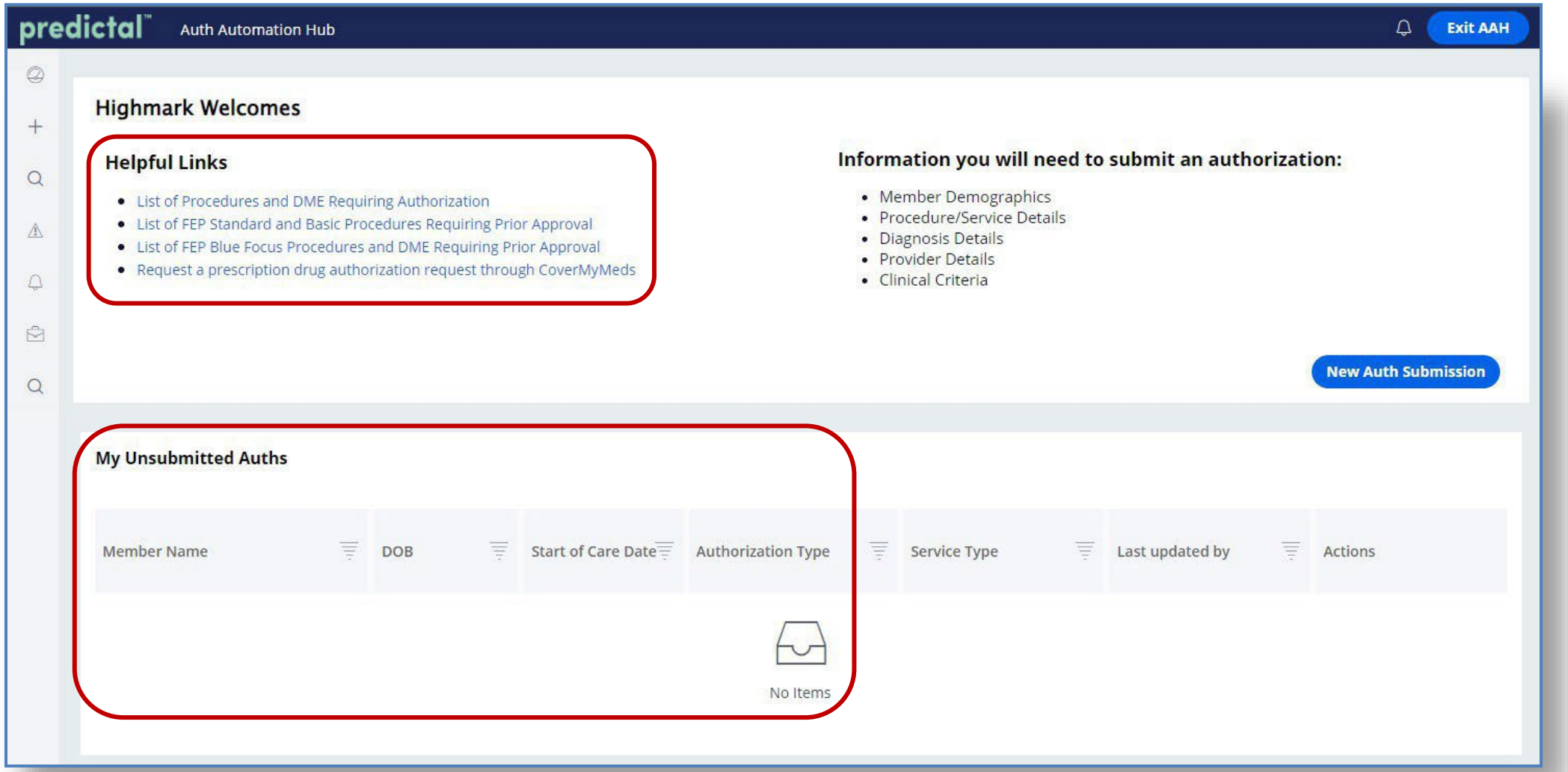
***Note**: This applies to any **Select an Organization** or **Select a Provider** list within Availity for HIGHMARK.*



*Also, refer to: https://apps.availity.com/availity/help-providers/source/portal_providers/account_administration/my_account/_topics/t_view_edit_team_member_role.html

The Predictal Auth Automation Hub (AAH)

The Predictal home page has links to the Prior Authorization List, CoverMyMeds submissions, and a view into authorizations that the user has started but not completed.

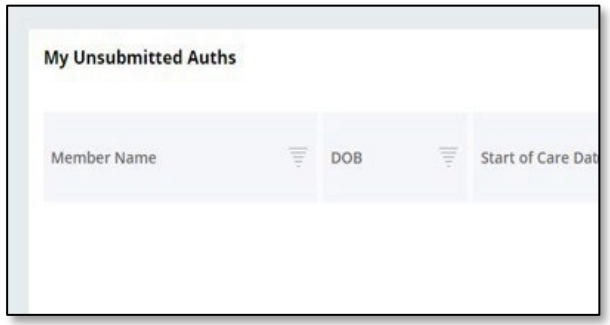


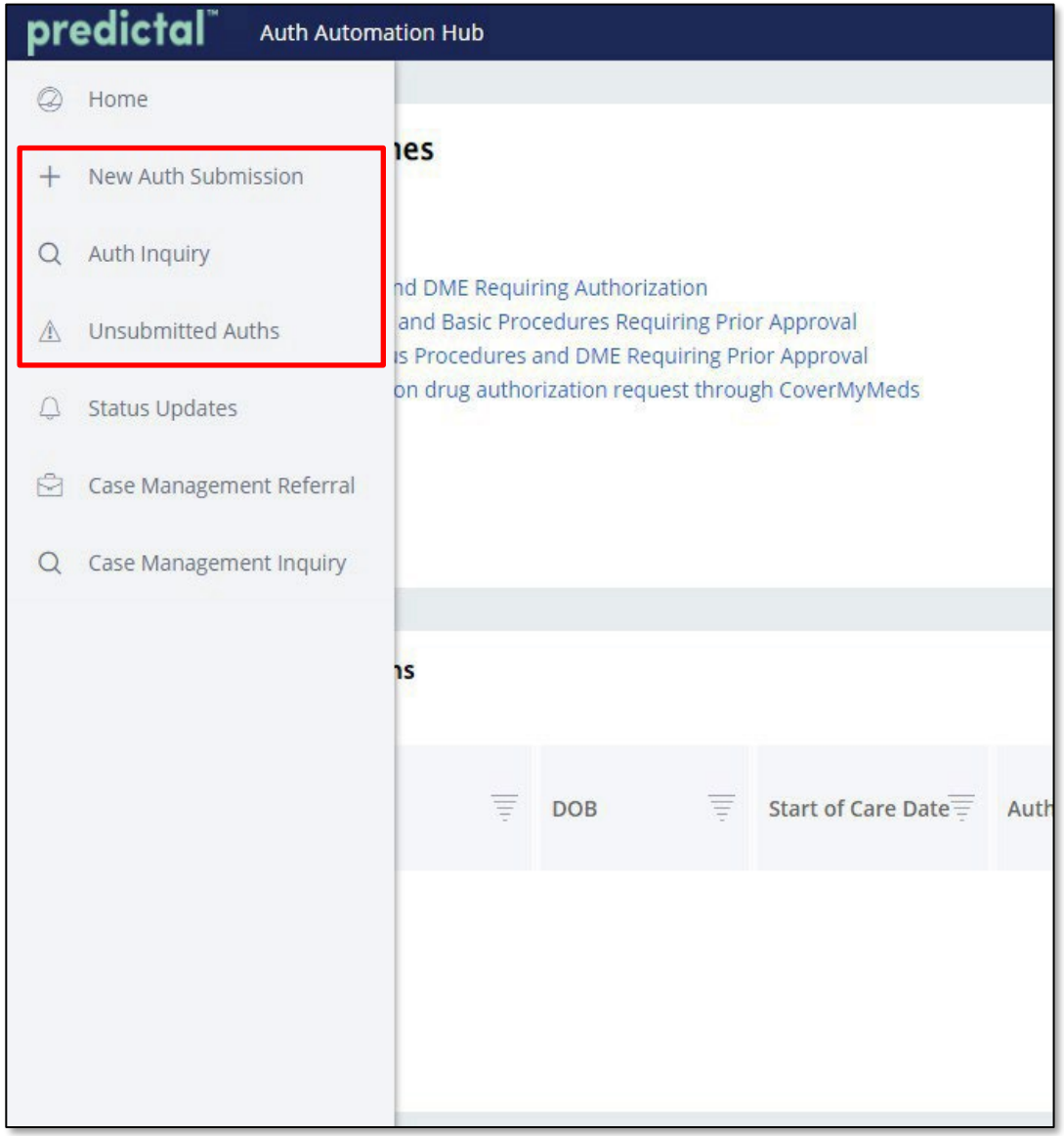
The left navigation panel includes links to the functions available within Predictal. Select **New Auth Submission** to initiate a new request. Select **Auth Inquiry** to do any of the following:

1. Check Authorization Status
2. Review Approval and Denial Letters
3. Discharges
4. Concurrent
5. Respond to a Request For Additional Information
6. Extension

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

Users can also view *all* **Unsubmitted Auths** on the Predictal home page.





New Authorization Submissions

The top menu bar in the Predictal Auth Automation Hub (AAH) will walk users through the steps of the electronic authorization submission process through **Confirmation**.

After each step listed in the top menu bar, users will be prompted to hit **Submit**. The authorization will not be submitted to Highmark until the *final* **Submit** on the **Confirmation** screen is selected *(Step 6 above.)*

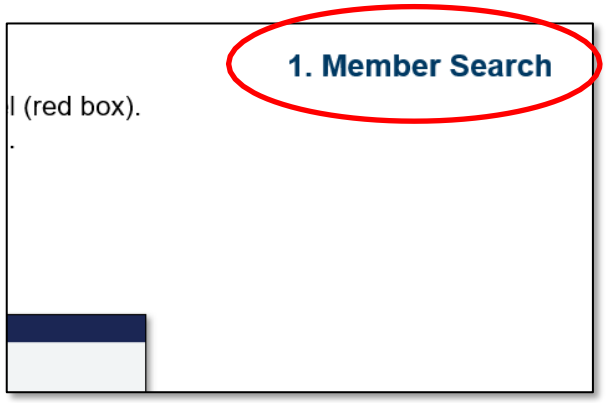
Throughout the authorization process, users will have the opportunity to **Save** their work without submitting. Hitting **Save** at the bottom of the screen will move the authorization request into the user's **Unsubmitted Auths** queue in Availity.

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

***Note:** In the upper right corner of the following slides, we've noted where the user is within the submission process:*

1. *Member Search*
2. *Authorization Details*
3. *Enter Provider*
4. *Review Guidelines*
5. *Review Authorization*
6. *Confirmation*

(Includes Helion Arc Submissions)

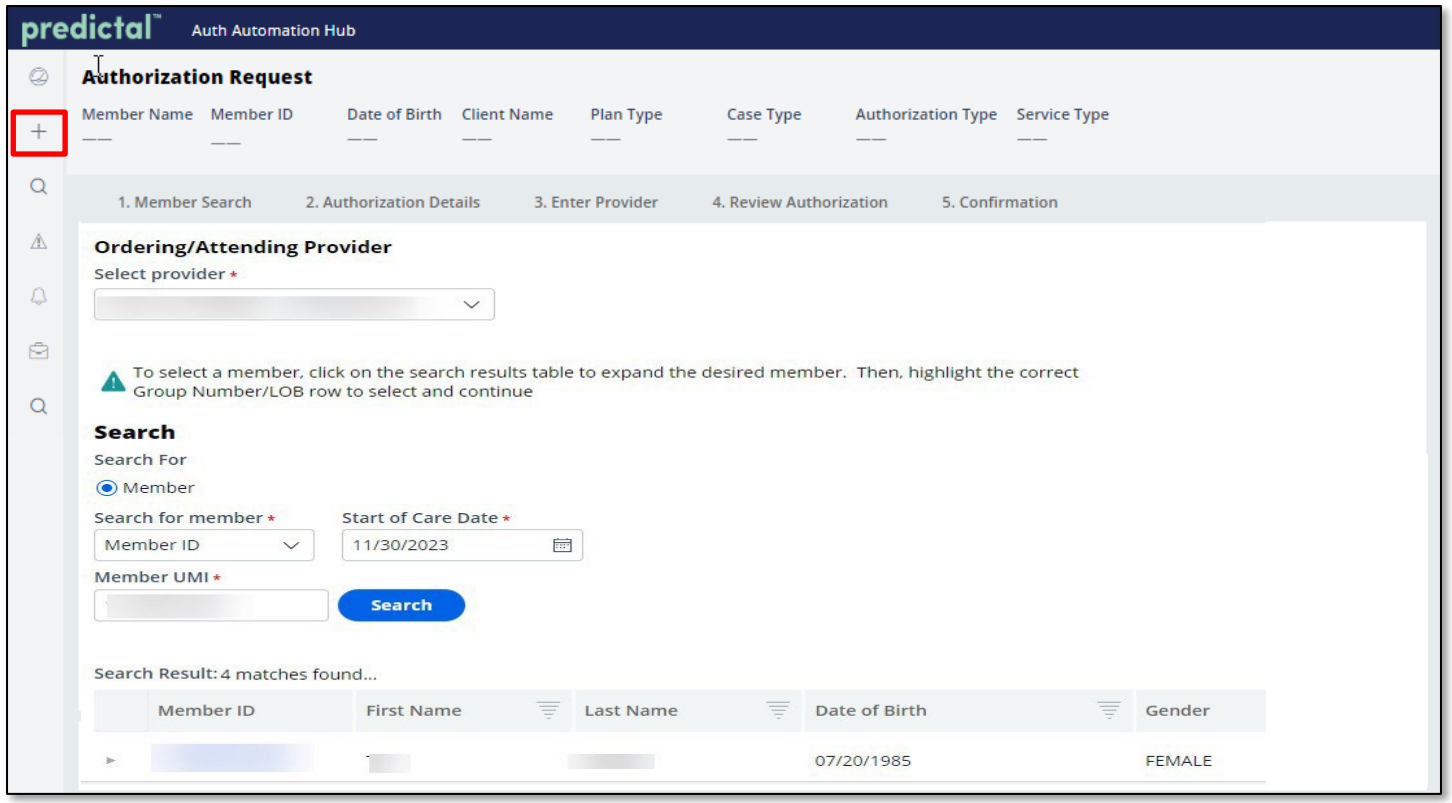


1. Member Search

For a new Authorization Request:

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

Search for the Member ID in the **Search for member** field.
Fill in the **Start of Care Date** which should be the date the request is being submitted. Select the blue **Search** button (the member information screen appears).

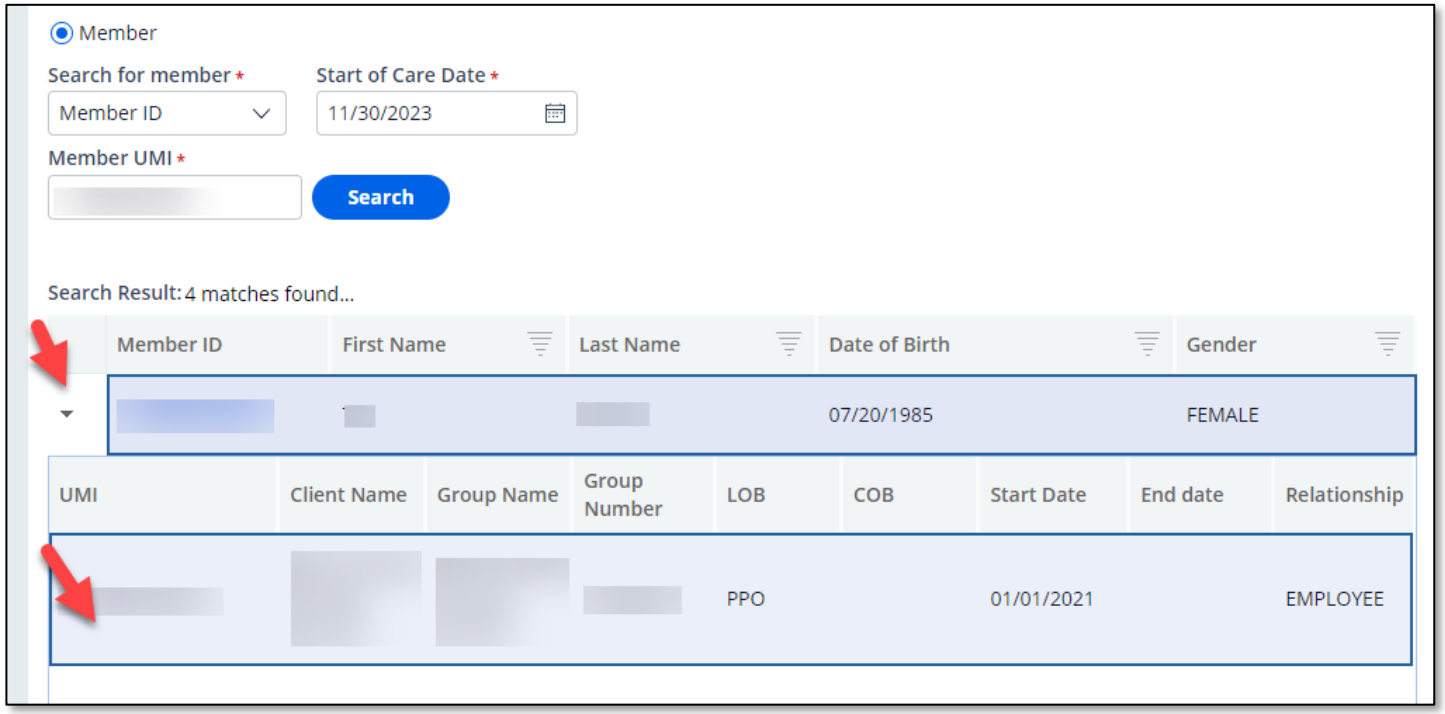


When results return, to select the appropriate member, users must complete the following steps to select the specific member:

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

Doing so will ensure that the authorization is being submitted accurately for the member on the policy.

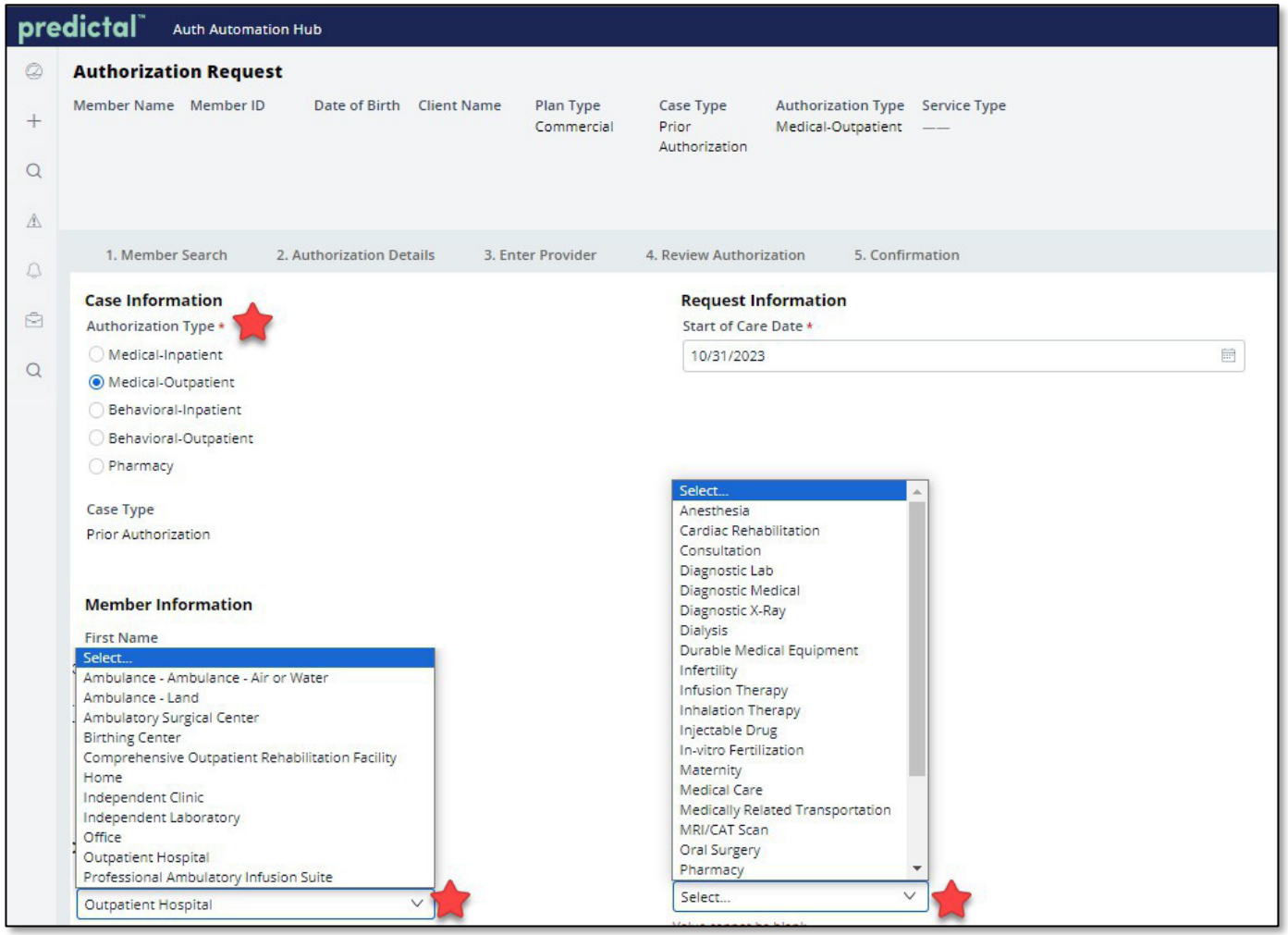
Finally, users select the blue **Submit** button to move to the next step.



2. Authorization Details

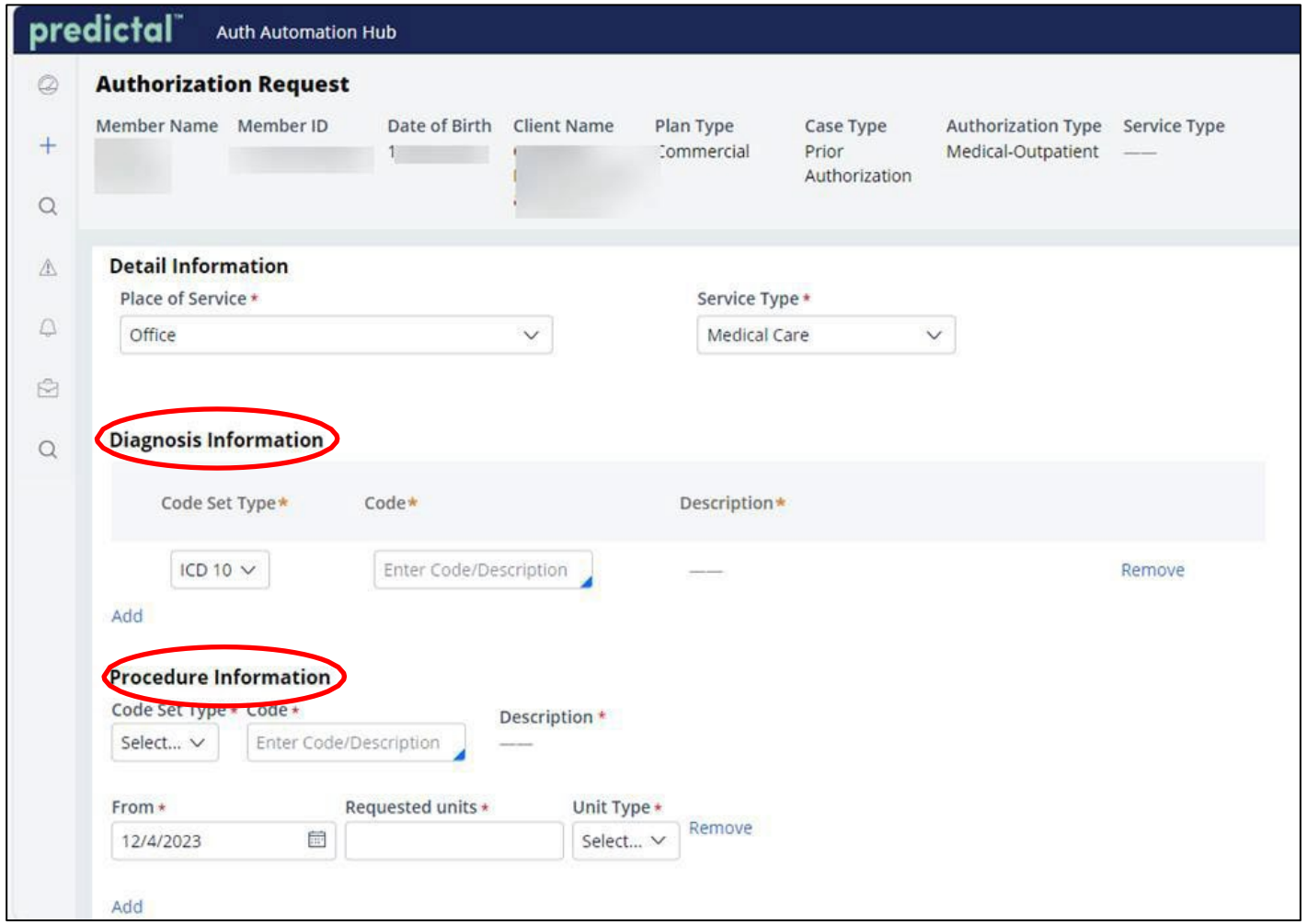
After users have completed the member information, they can move onto the following steps:

1. Select the **Authorization Type**
2. Select the **Place of Service**
3. Select the **Service Type**

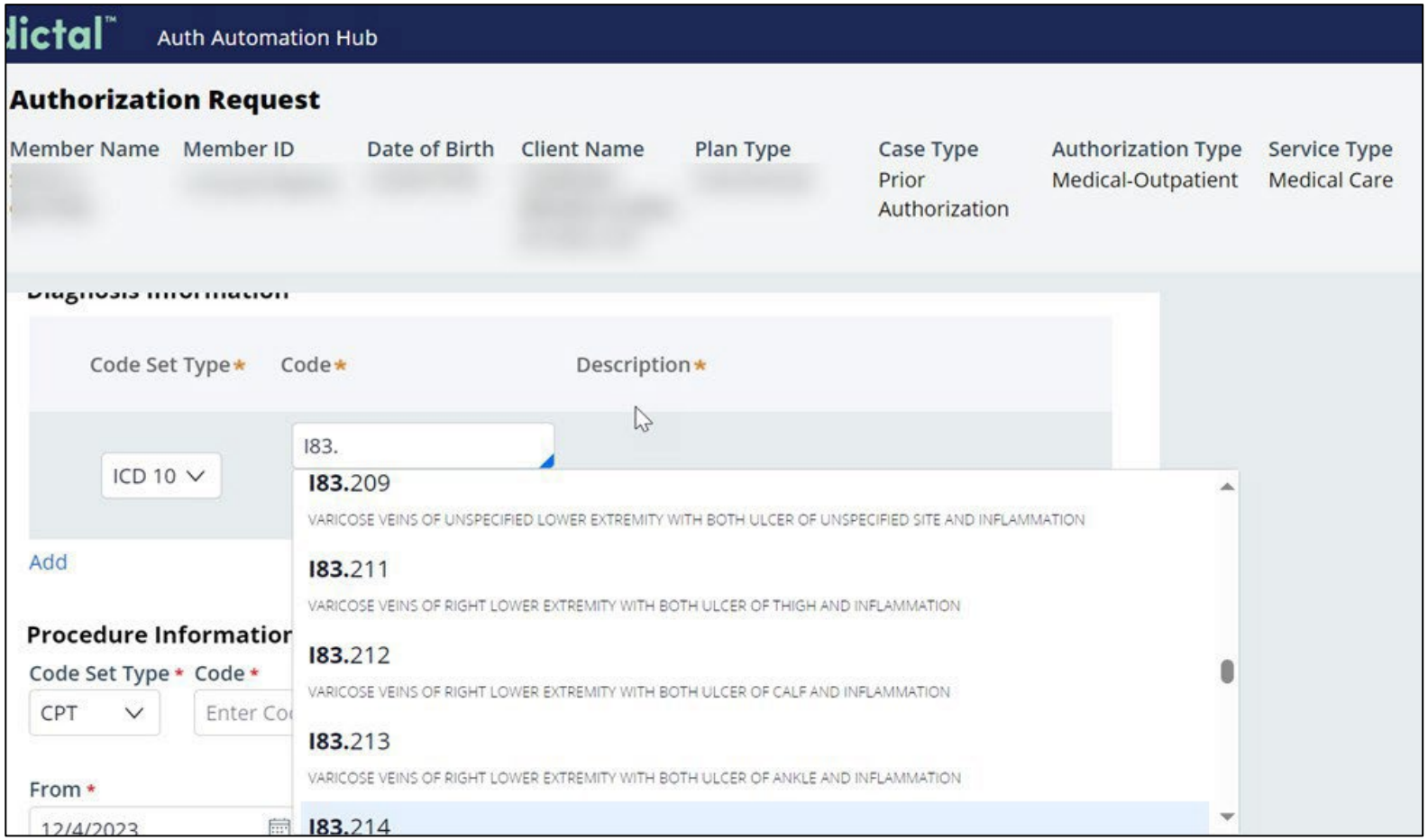


2. Authorization Details

Scroll down the page and complete the **Diagnosis Information** and **Procedure Information**.

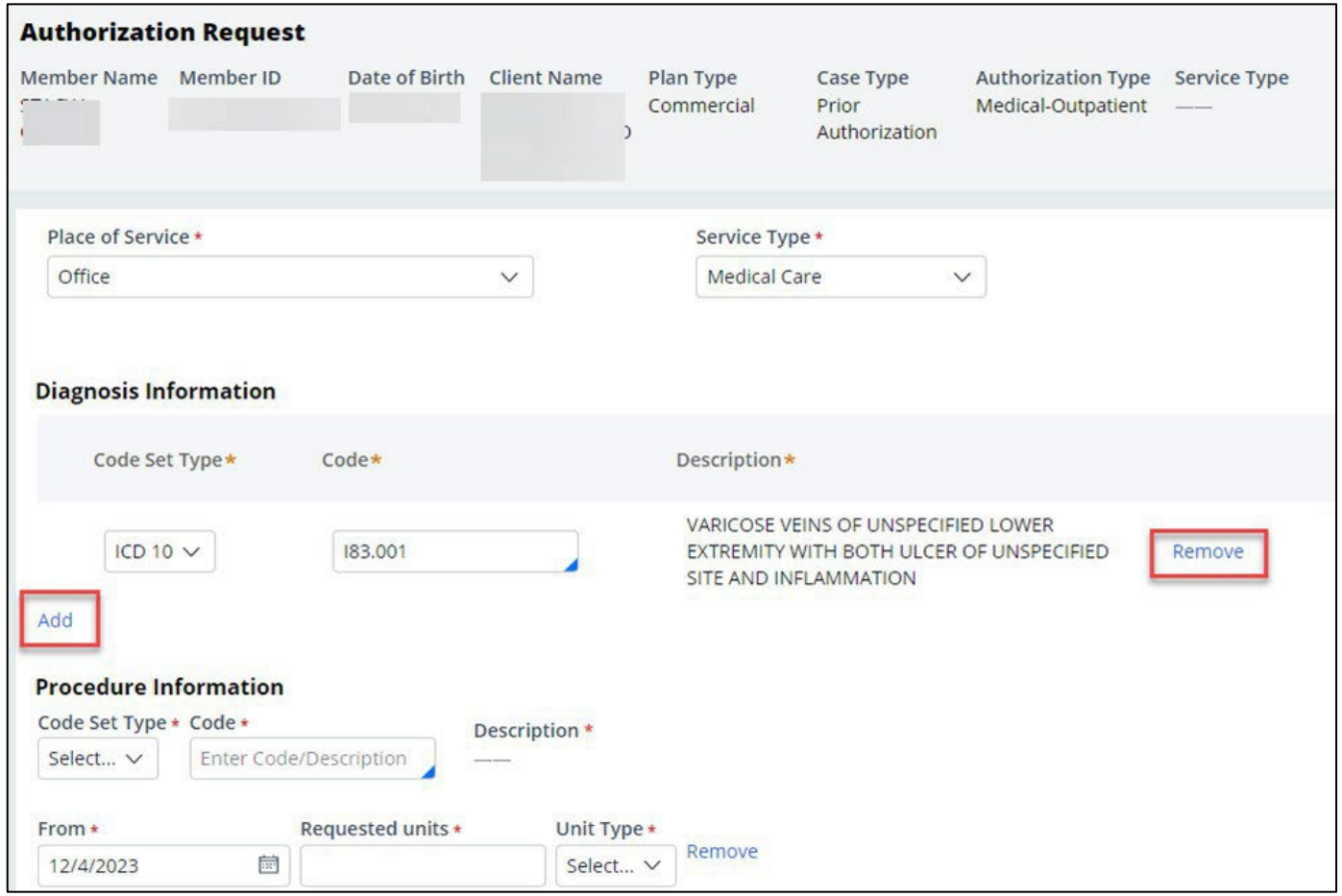


In the **Diagnosis Information** section, users should enter the entire diagnosis code. Make your selection once the screen populates.
*(**Note:** The code must include the decimal point when entering a diagnosis).*



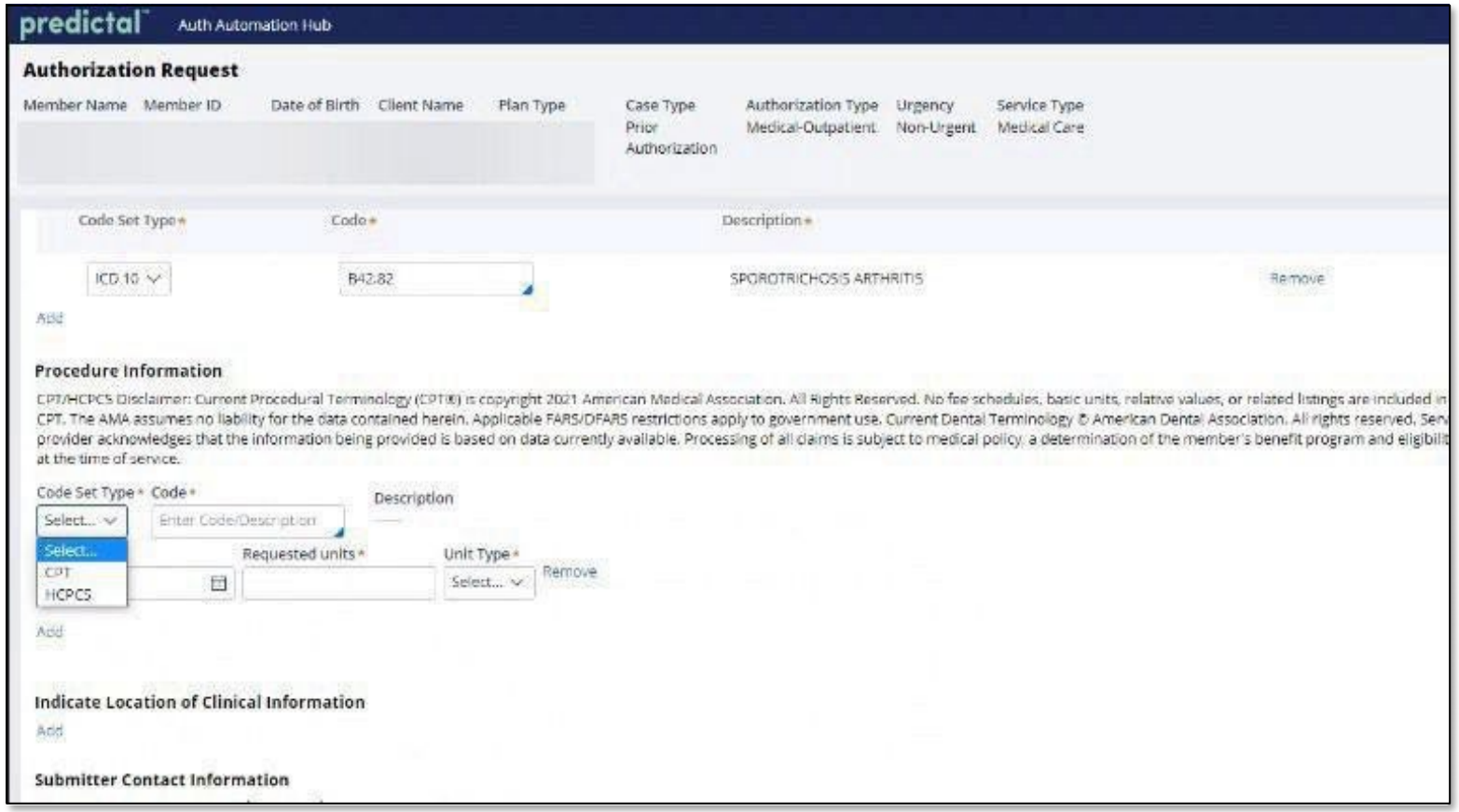
If an incorrect code was entered, users can click the **Remove** link to delete that diagnosis from the request. Select the **Add** link to add additional diagnosis codes.

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



When entering the **Procedure** information, users **must** select the appropriate **Code Set Type**. If this is not selected, the procedure code will not be found.

Note: When entering an eviCore- or a Helion-managed authorization, users will not be asked for the procedure code until later in the workflow.

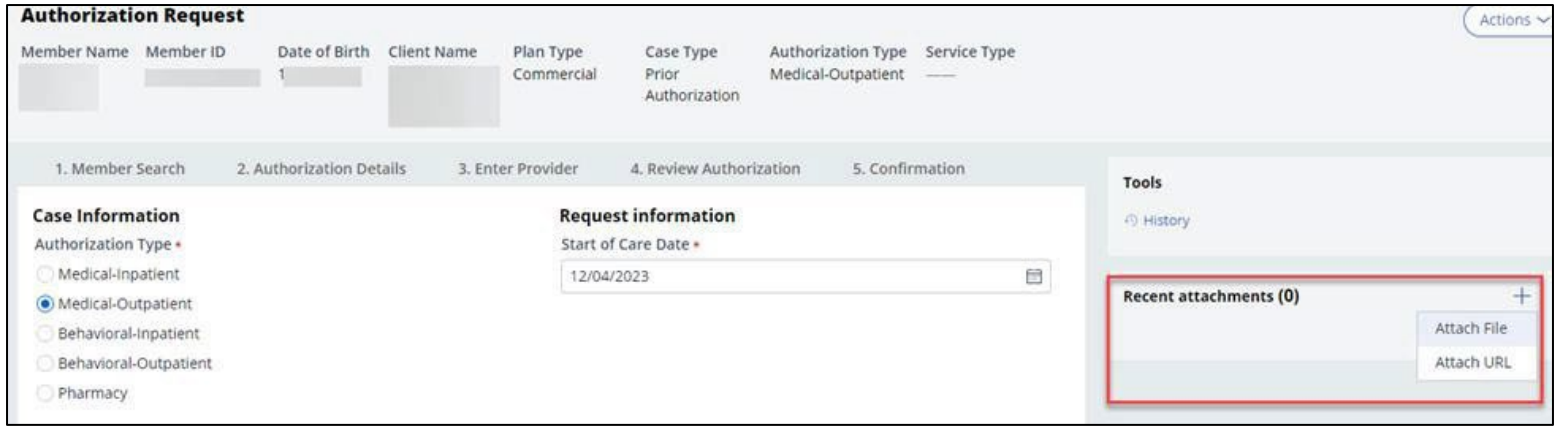


Note: A **CPT Code** is a 5- digit numeric code.

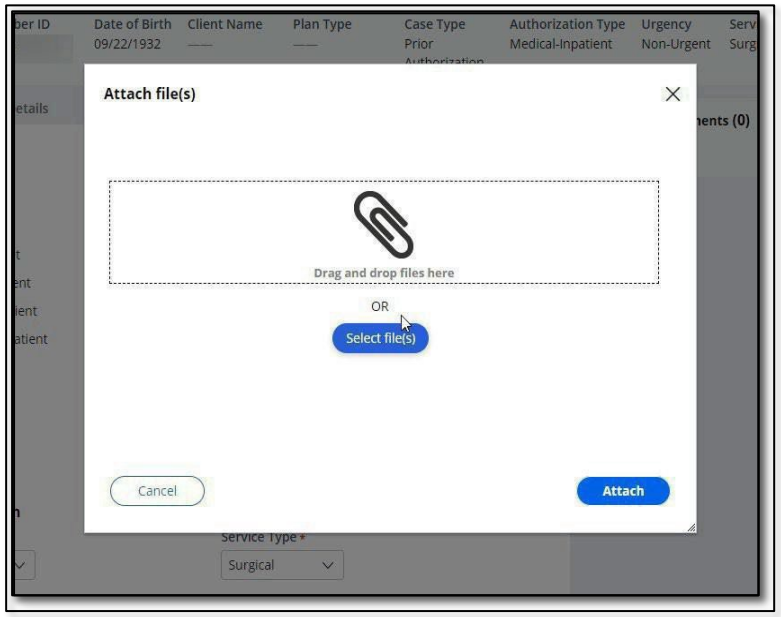
A **HCPCS Code** is a 5-digit code that begins with an alphanumeric value.

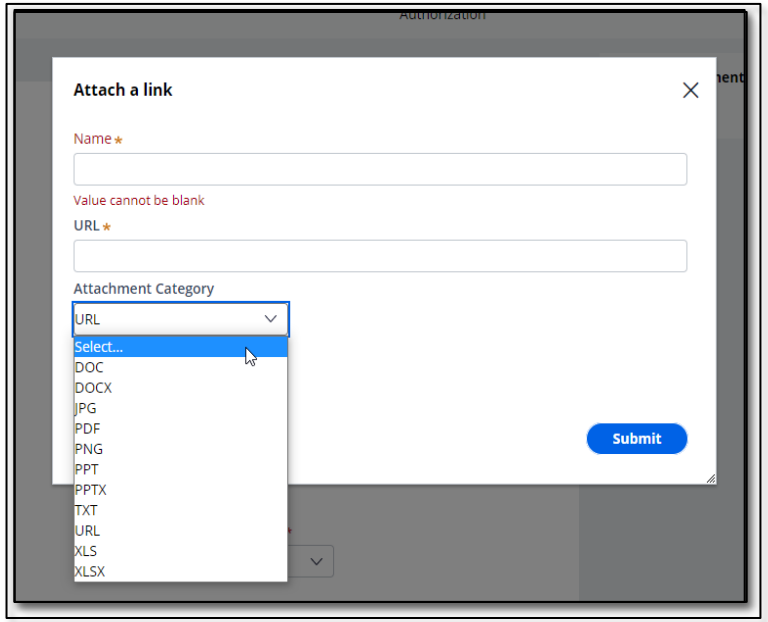
2. Authorization Details

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



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



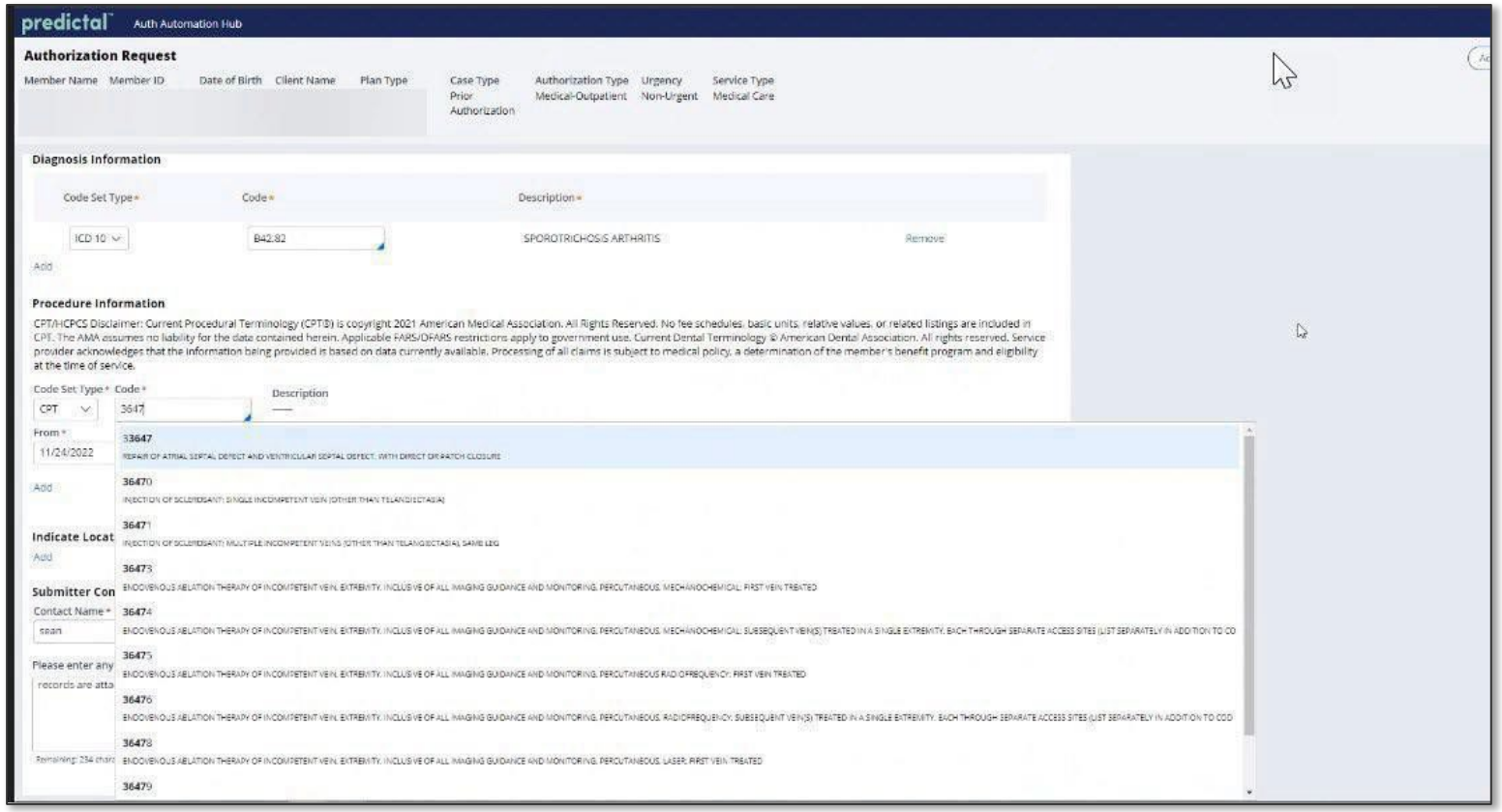


Note: **If the authorization is for anything non-delegated, the user will have the opportunity to utilize MCG criteria later in the workflow. Utilizing MCG criteria and attaching any supporting documentation will greatly reduce response time as well as provide additional clinical documentation to support the inpatient request.**

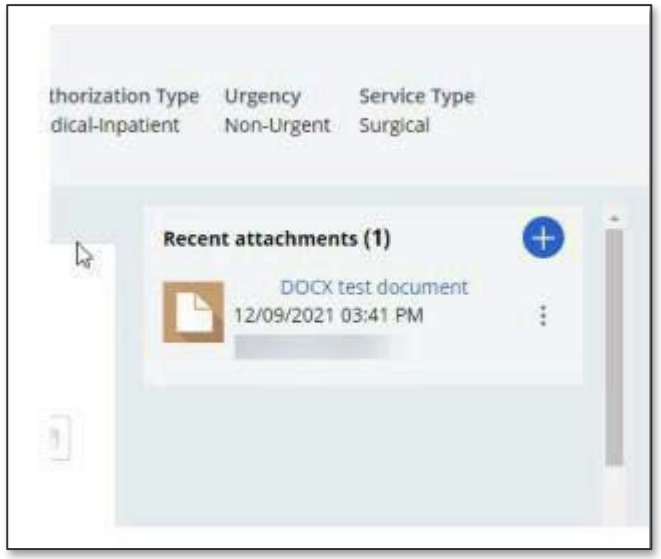
Once the **Code Set Type** has been selected:

- Enter the entire procedure code and select that code. (Use the actual code to avoid searching for the description.)
- Next, complete the remaining required fields.
- Users can select **Remove** if something has been entered incorrectly. If the user needs to authorize more than one procedure code, click the **Add** link.

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

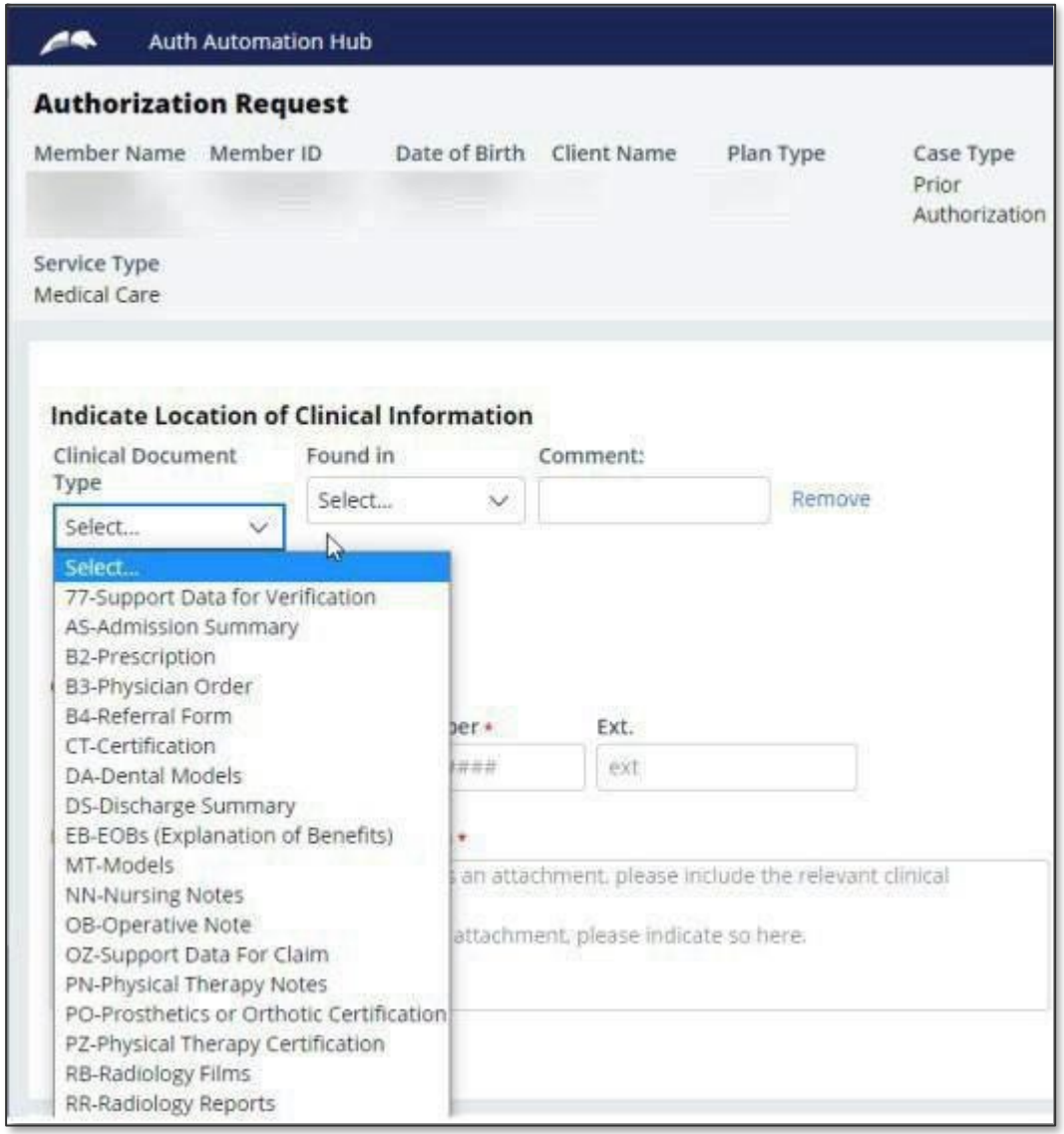


(This screenshot is only a CPT code example.)



When a document has been attached in the **Recent Attachments** section, users should complete the **Indicate Locations of Clinical Information** section to 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 can be found on page 3 of attachment"

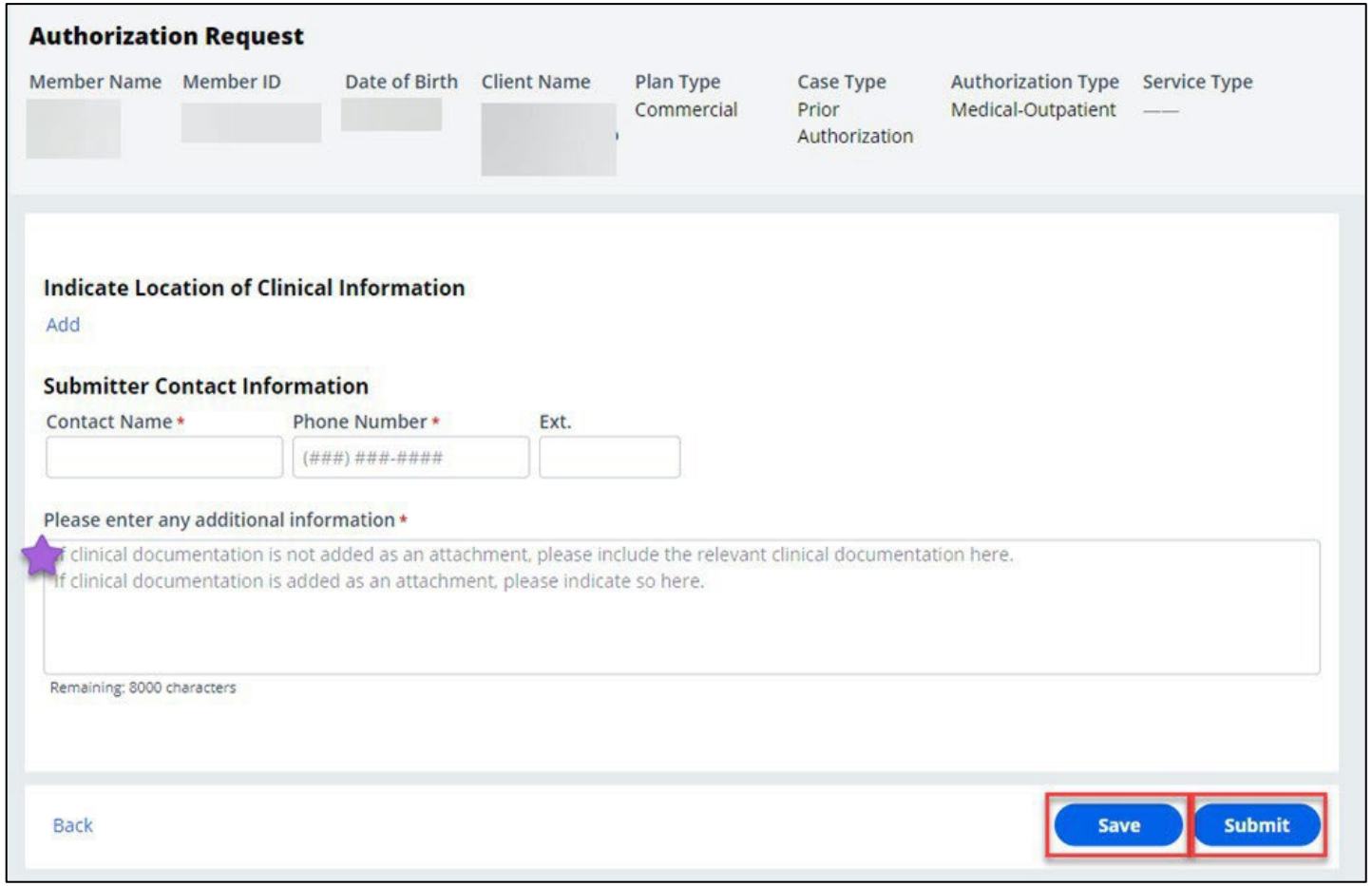


Completing the **Caller Information** section by:

- Noting any additional clinical information *(**Note:** there is a 225-character limit)*
- If information is not added in an attachment, include the necessary clinical information here
- If the clinical information is added as an attachment, please note that here also (this is a mandatory field)
- The **Save** button allows users to bookmark work and can return to it (recycles the same page)

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

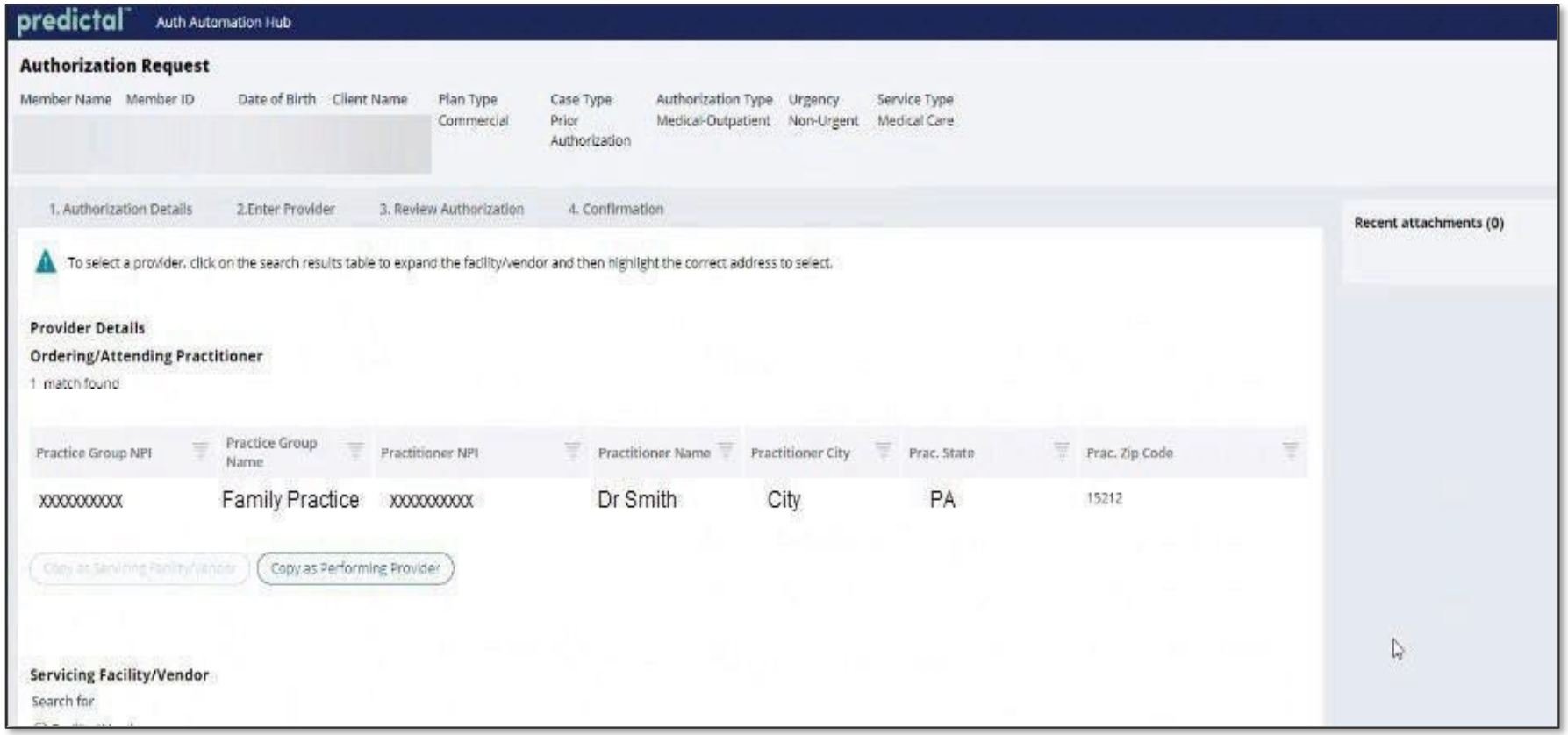
When all fields are complete, click **Submit.**



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 provider's location.

Here is the **Copy As Servicing Facility/Vendor** / **Copy As Performing Provider** link that allows users to copy the **Ordering/Attending Practitioner** information into the **Servicing Facility/Vendor** or **Performing Provider** information.

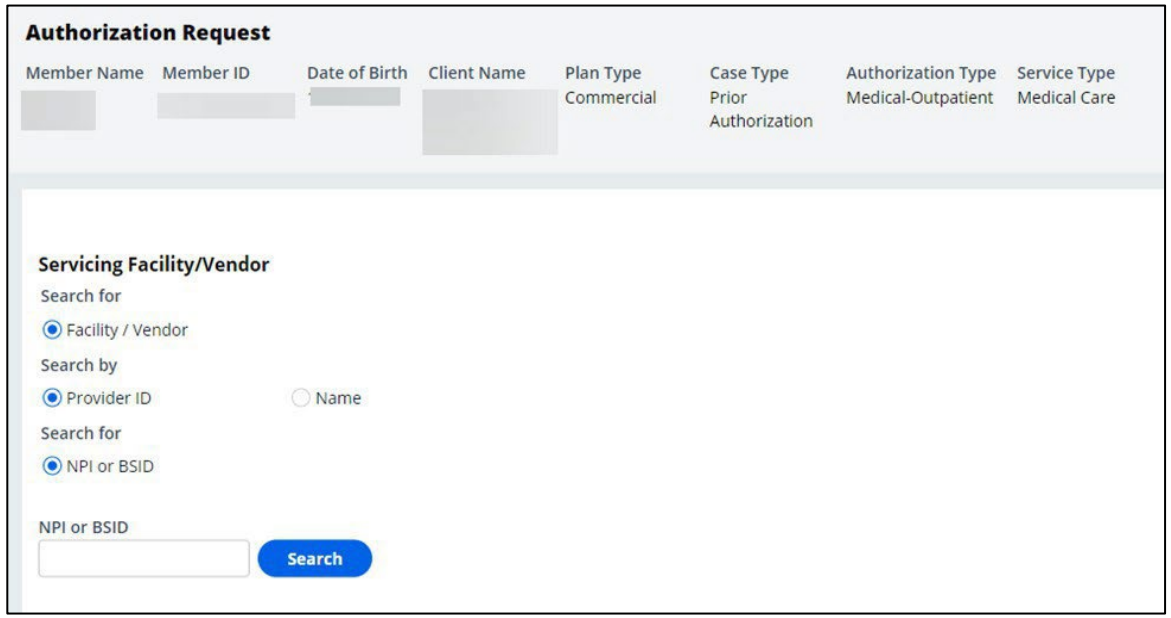


3. Enter Provider

If the copy links do not work, then users can search for the **Service Facility/Vendor** by:

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

(Note: this is a mandatory field.)



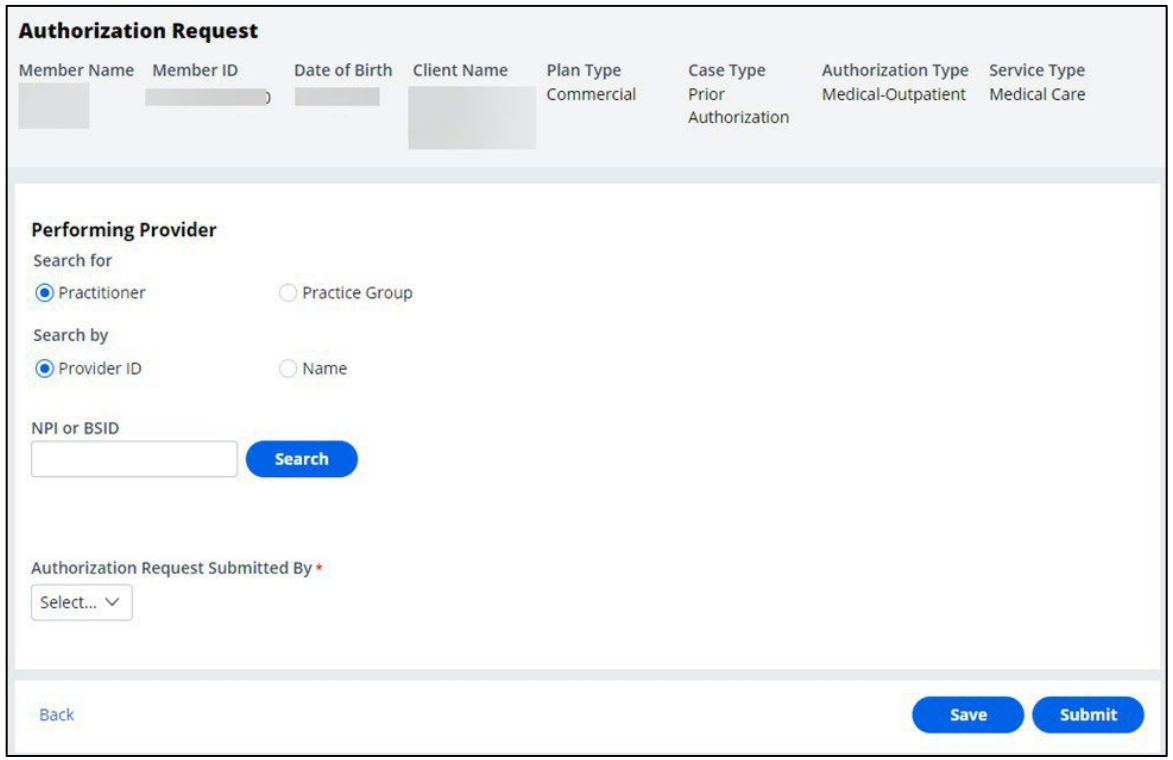
Search for the **Performing Provider (**Practitioner) by using:

- Provider ID (using the NPI or Blue Shield BSID)
- Name

Or by **Practice Group** using:

- Provider ID (using NPI, BlueShield BS ID or Tax ID)
- Name

(Note: This is a mandatory field.)



3. Enter Provider

When results return, to select the appropriate facility/vendor, users 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. Users can then move on to the next fields to repeat the same steps for the:

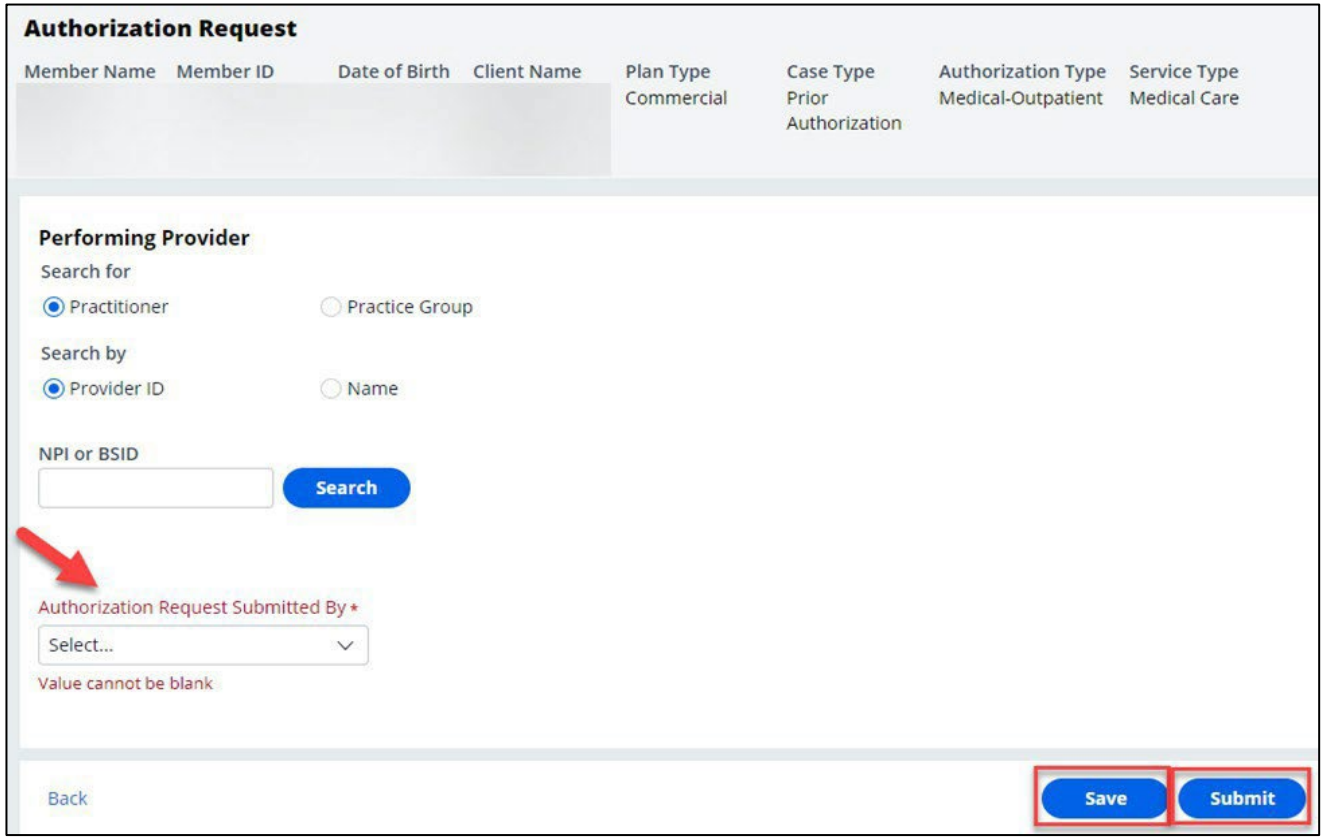
- **Ordering/Attending Practitioner**
- **Servicing Facility** and
- **Performing Provider**..

Note: *There is a blue **Edit** button to the right of this screen where the provider can change contact information.*

3. Enter Provider

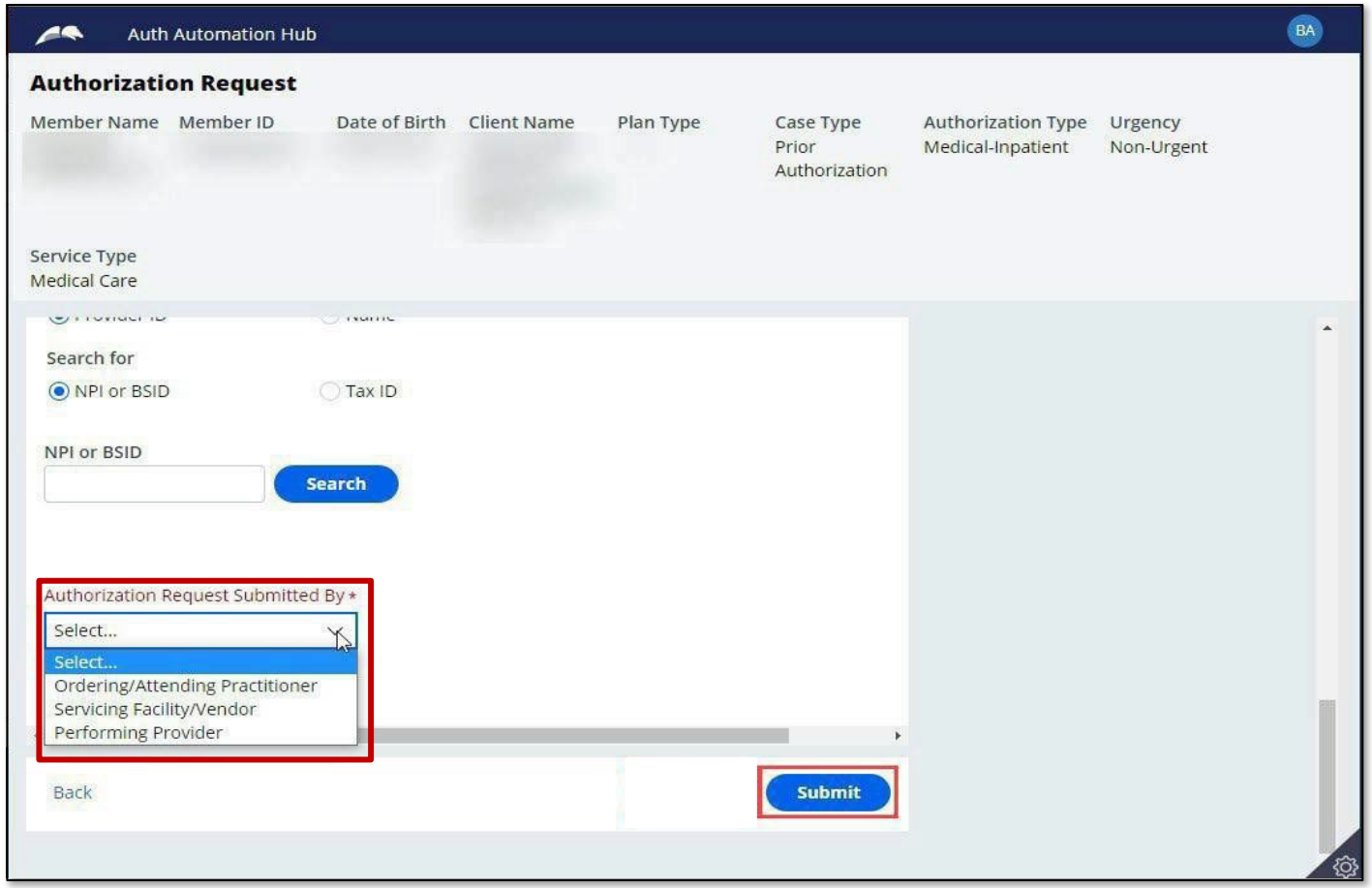
Select the name of the provider who is requesting the authorization from the **Authorization Request Submitted By** dropdown. The blue **Save** button allows users to bookmark where they are inputting data.

Click **Submit** when all the fields have been completed.



3. Enter Provider

Select the provider who is requesting the authorization in the **Authorization Request Submitted By** dropdown. Click **Submit** when all information has been completed.



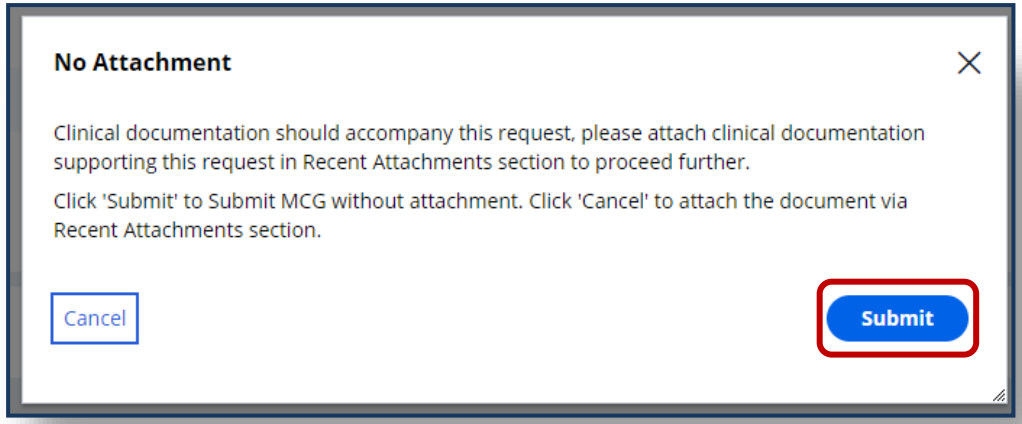
Invoking MCG Criteria

Effective Oct. 14, 2024, Highmark launched a new enhancement to the Predictal Auth Automation Hub that will streamline the authorization review process, saving time and effort for providers and their teams. When submitting a prior authorization request, providers and licensed clinical personnel will now be able to invoke MGC's clinical criteria, triggering a faster review of their request.

IMPORTANT NOTE: *Non-clinical staff will not be able to use this enhancement, and all users will be able to bypass the MCG process. As MCG questions arise during the authorization request, Highmark's clinical staff can only communicate with the Provider or another licensed clinical staff member.*

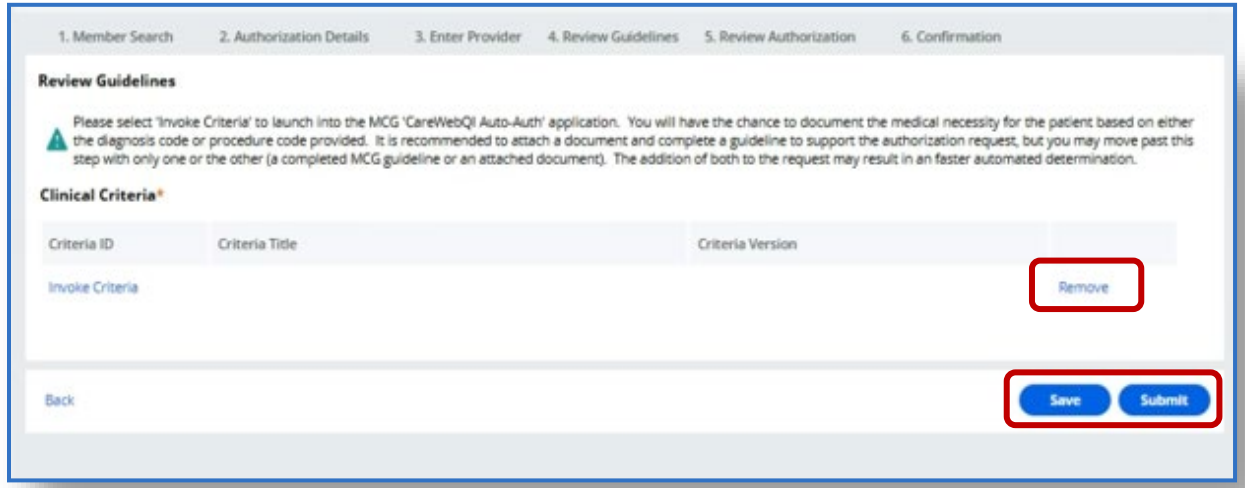
Bypass for Attaching Clinical Documentation

If the user attempts to invoke criteria *before* attaching clinical documentation, the system will alert the user with the pop-up warning message *(as seen here to the right).*



Providers will have the option to bypass this page by clicking **Remove** in the lower right section of the screen. Select the blue **Save** button after each action, and select the blue **Submit** button to submit the authorization.

Please Note: *Choosing to bypass the criteria may result in a longer processing time for your authorization request. We encourage all providers and licensed clinical personnel on your team to utilize the criteria system whenever possible to expedite your authorizations.*



The Former Process

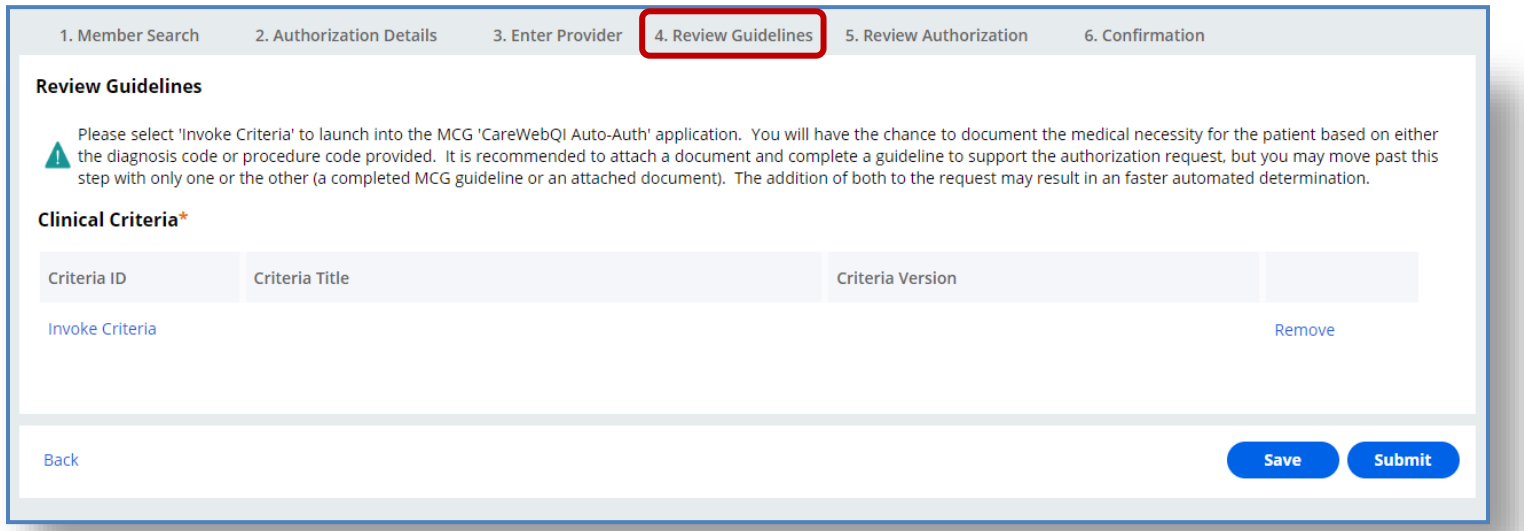
The former authorization submission process was a 5-step process:

1. Member Search
2. Authorization Details
3. Enter Provider
4. Review Authorization
5. Confirmation

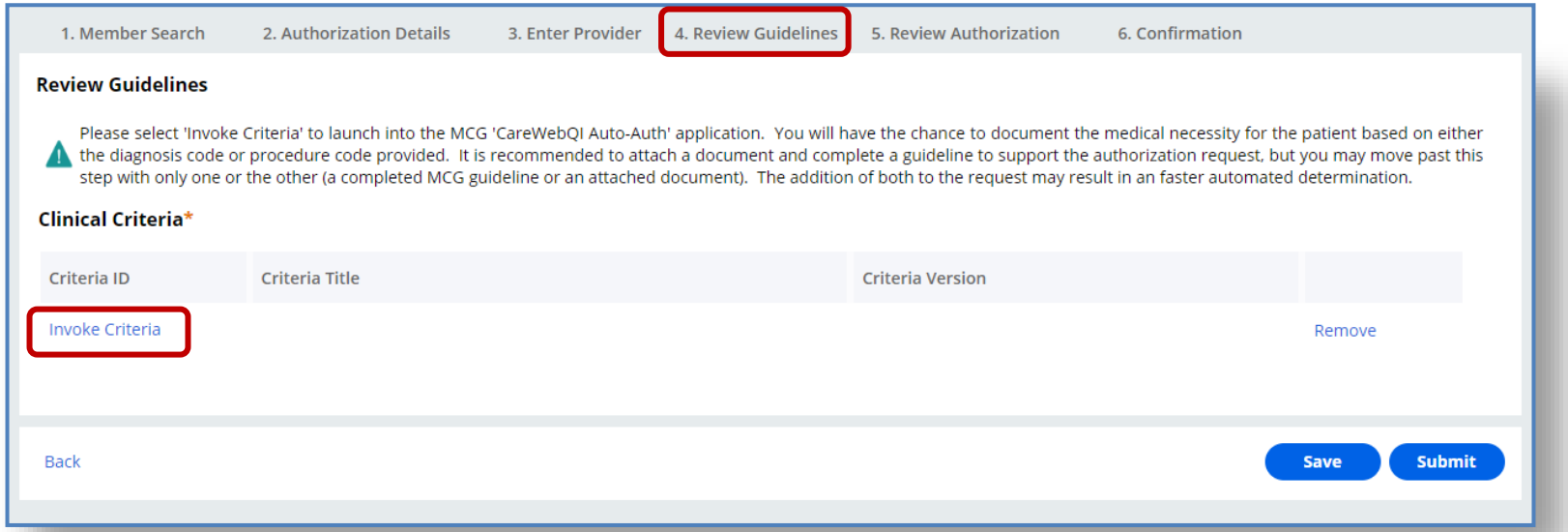
What Has Changed?

With the addition of the MCG enhancement, a new step (**Review Guidelines**) has been added, making authorization submission now a 6-step process:

1. Member Search
2. Authorization Details
3. Enter Provider
4. Review Guidelines
5. Review Authorization
6. Confirmation



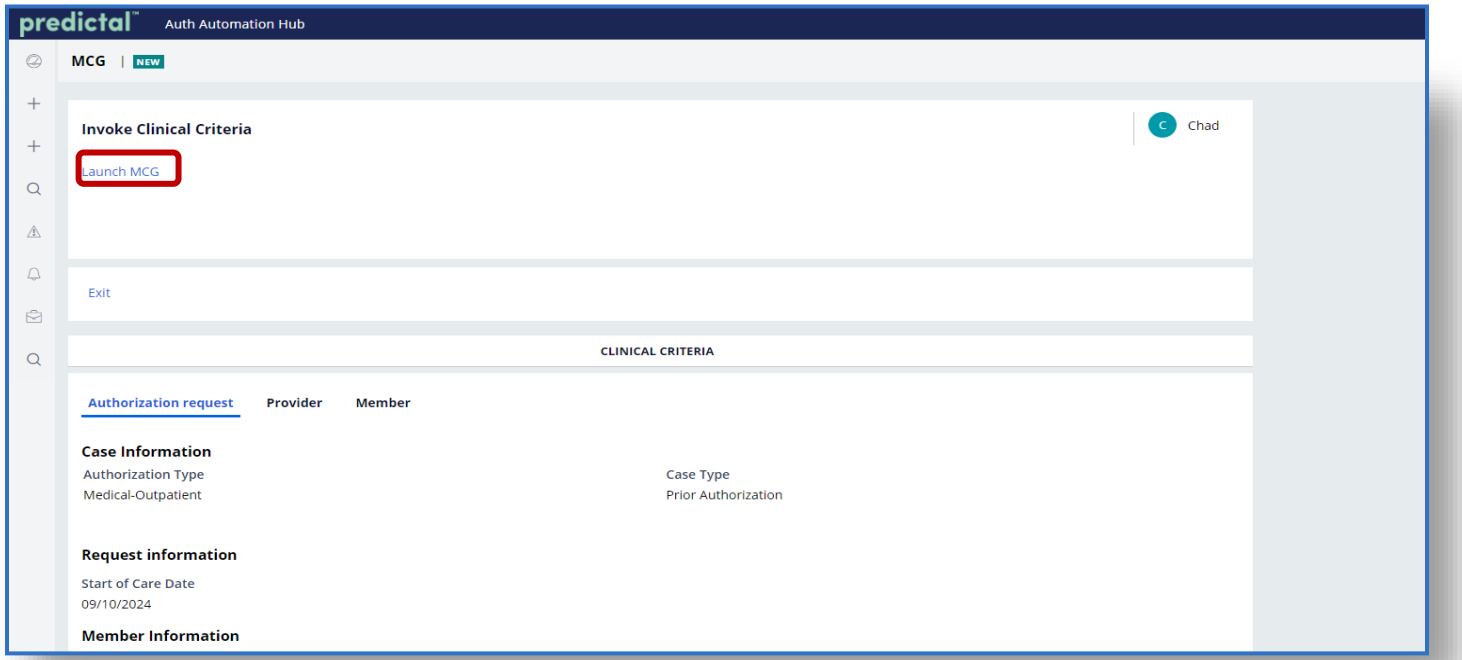
Once **Step 3** is complete, authorizations for services managed by Helion, eviCore, or another third-party administrator will redirect the user to those sites to continue their submission process outside of Predictal. *(See later in this guide.)* For authorization requests routing through Predictal, these submissions will arrive at **Step 4: Review Guidelines:**



Under **Step 4,** providers and other users will have the opportunity to **Invoke Criteria** in the form of an MCG guideline or custom policy that will support the need for the patient's requested care. Invoking criteria ***(when clinical documentation has been attached)*** will streamline the review process and may result in a faster approval for appropriate treatment. Select the blue **Invoke Criteria** link and the **Invoke Clinical Criteria** pop-up window will appear *(see next slide).*

Attaching relevant clinical document and invoking criteria submission also decreases the administrative burden for both providers and the health plan. If providers and licensed clinical personnel do choose to attach a document and launch the MCG application after selecting the **Invoke Criteria** link, users will see the **Invoke Clinical Criterial** pop-up window *(as shown below):*

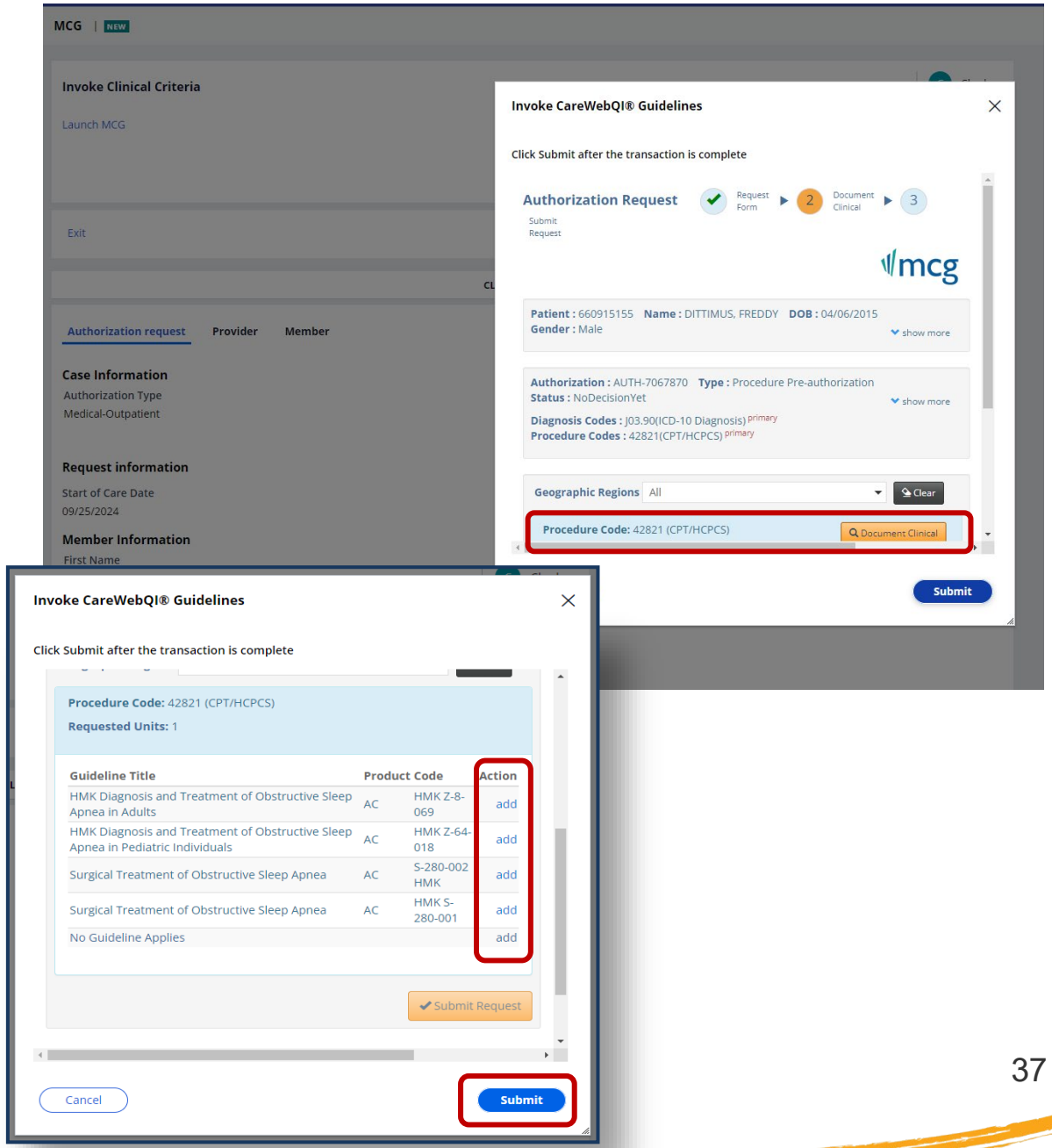
- Select the blue **Launch MCG** link to activate the **MCG Invoke CareWeb Guidelines** form *(seen on the next slide)*
- *(**Note:** See the authorization information previous input below under the **Clinical Criteria** section)*



4. Review Guidelines

Providers will see the CPT/HCPCS code or diagnosis code from their request next to the orange **Document Clinical** button (guidelines appear). Click on the button that shows the most applicable guidelines or custom policies related to the CPT/HCPCS or diagnosis code.

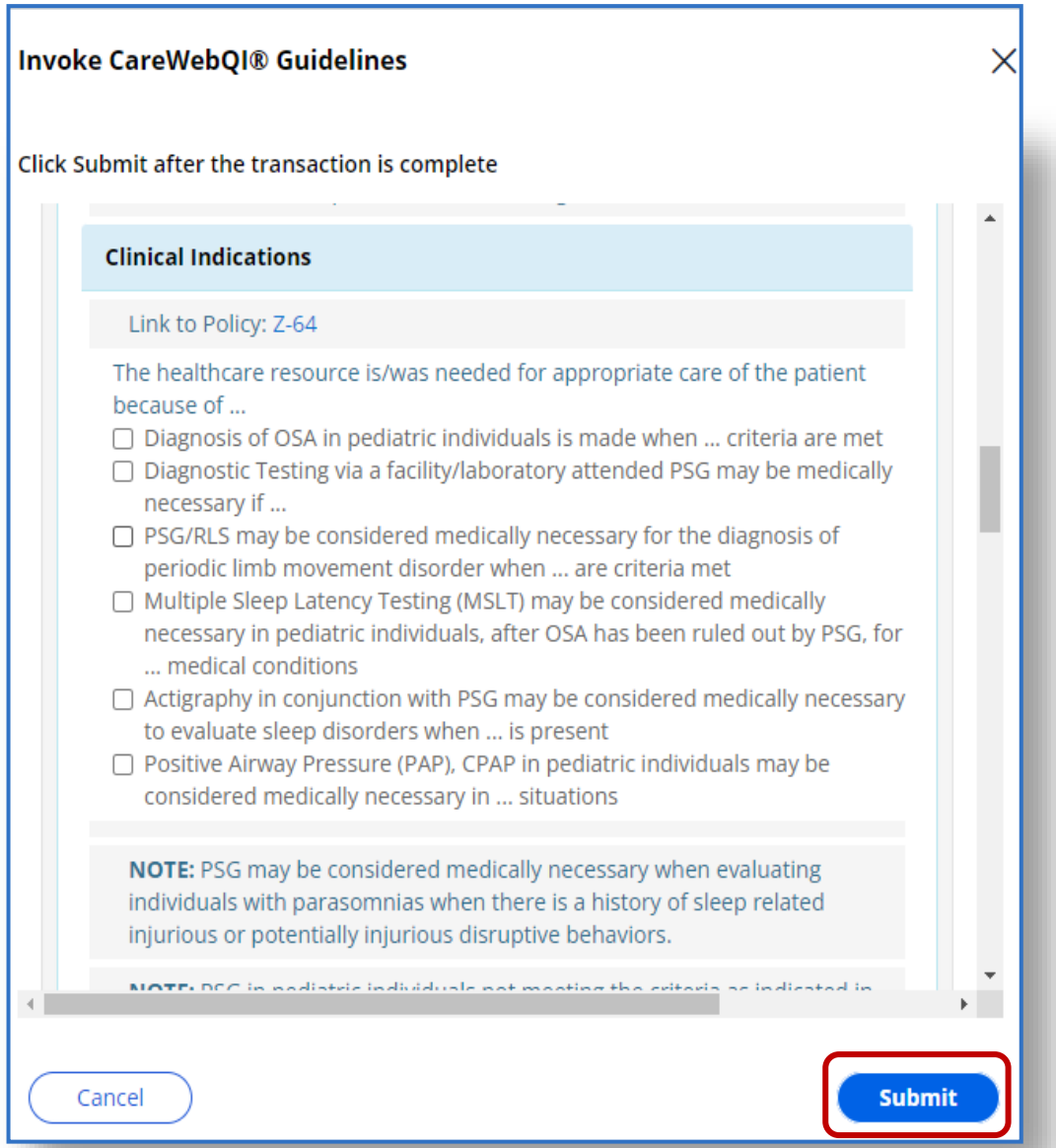
Select the guideline and product type that matches the request and click the blue **add link** at the end of the guideline. After selecting **add**, users will be shown the information that they can select to support their need for an authorization *(see the clinical detail on the next slide).*



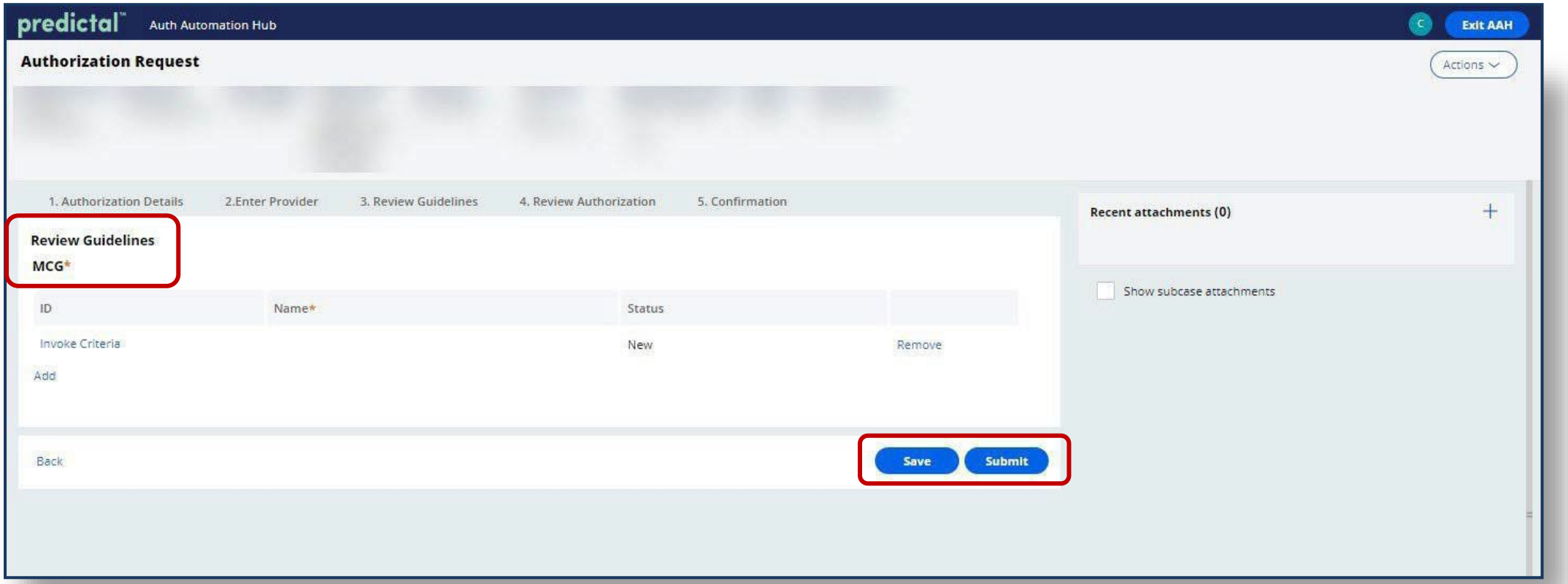
4. Review Guidelines

Before attaching any MCG guidelines, users can view the detailed guidelines and select each of the relevant **Clinical Indications** that substantiate the need for the auth request's care or procedure as warranted.

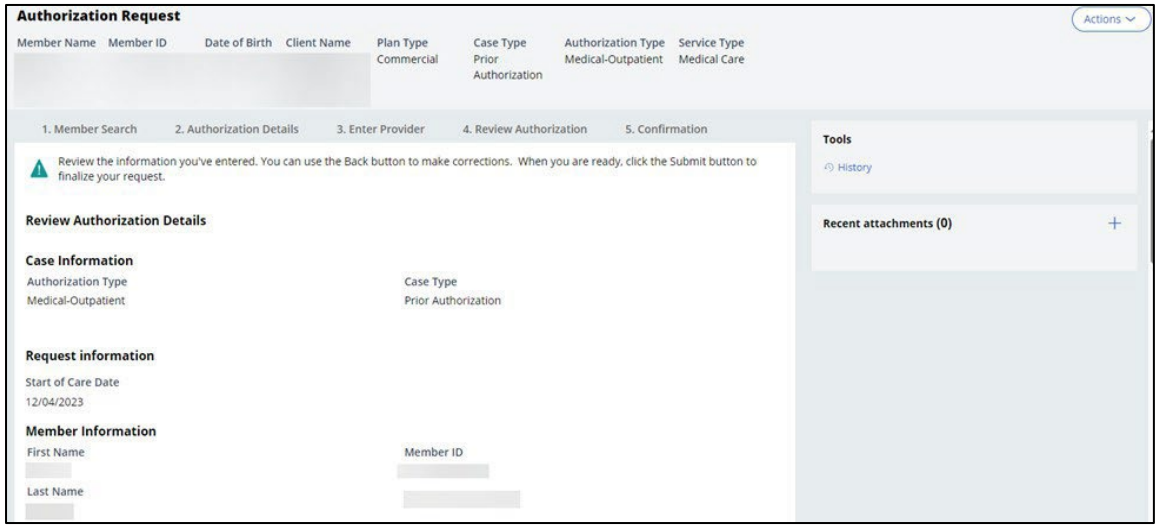
Check off any of the appropriate reasons listed, and then select the blue **Submit** button to complete the Invoke MCG Criteria process.



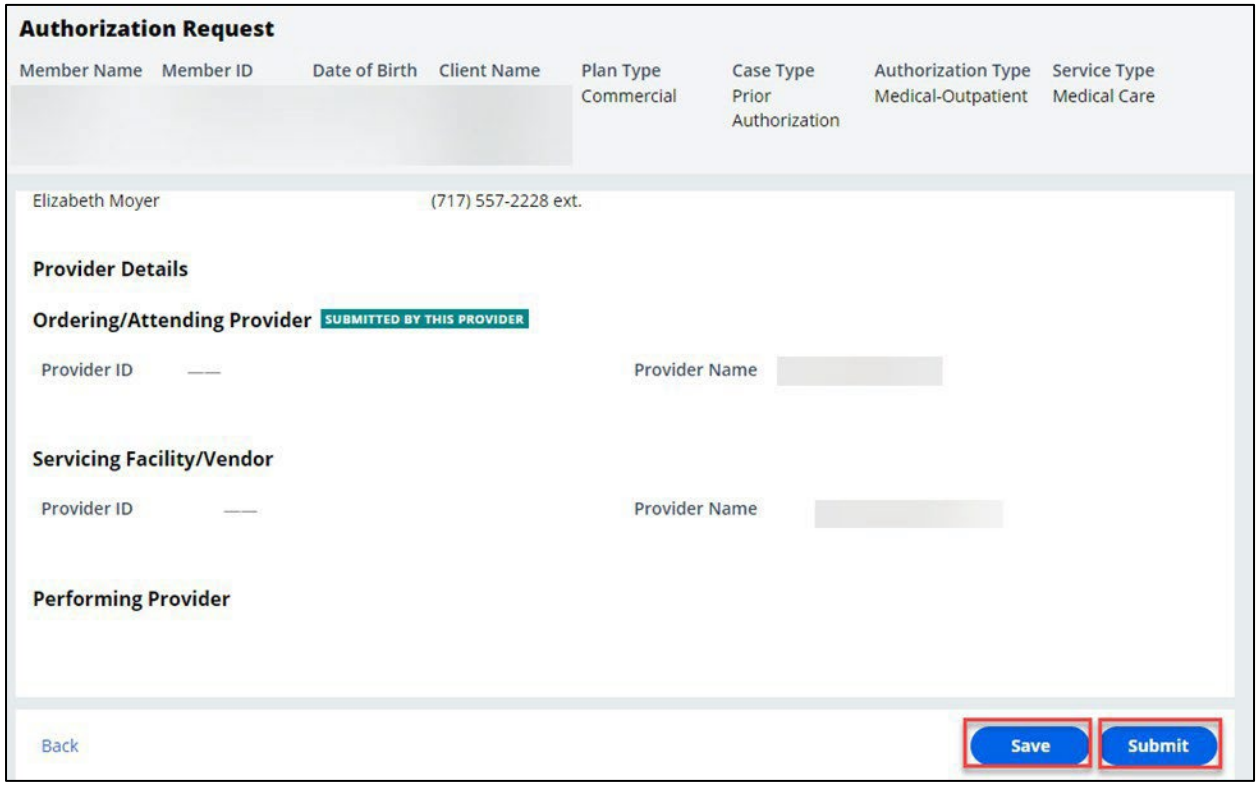
The MCG data requested will appear in the main **Authorization Request** window under the **Review Guidelines MCG** section of the screen. Complete the attachment of the MCG Criteria by selecting the blue **Save** button after adding each criteria. Finally, select the blue **Submit** button to complete **Step 4**.



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

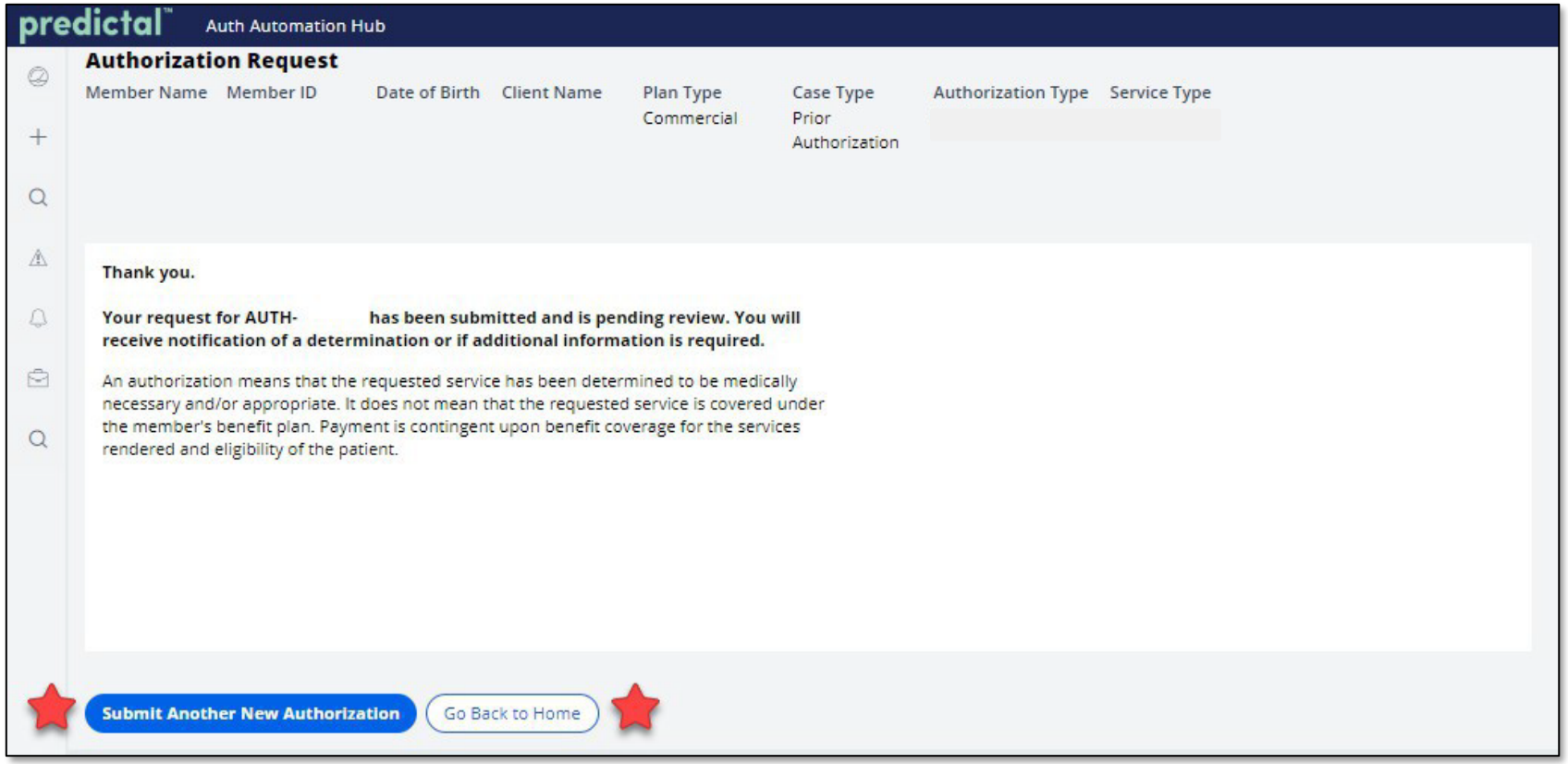


Scrolling to the bottom will allow users to select the blue **Submit** button. This is the **final submission** which will send the user the authorization request for final review.

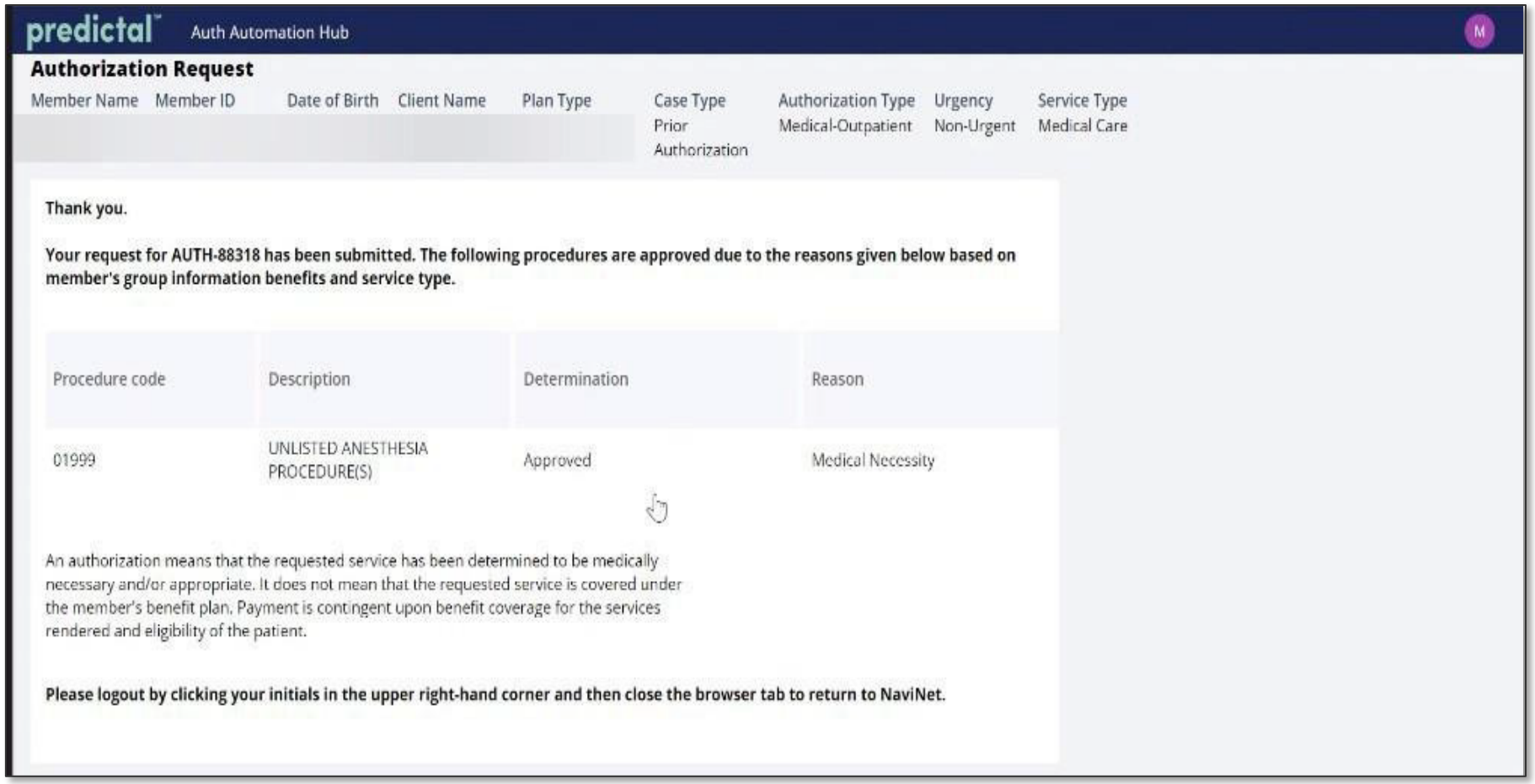


When the authorization is submitted, a reference number will be displayed (AUTH-_____).
Note: *Users do not receive an official Authorization Number until the review is complete.*

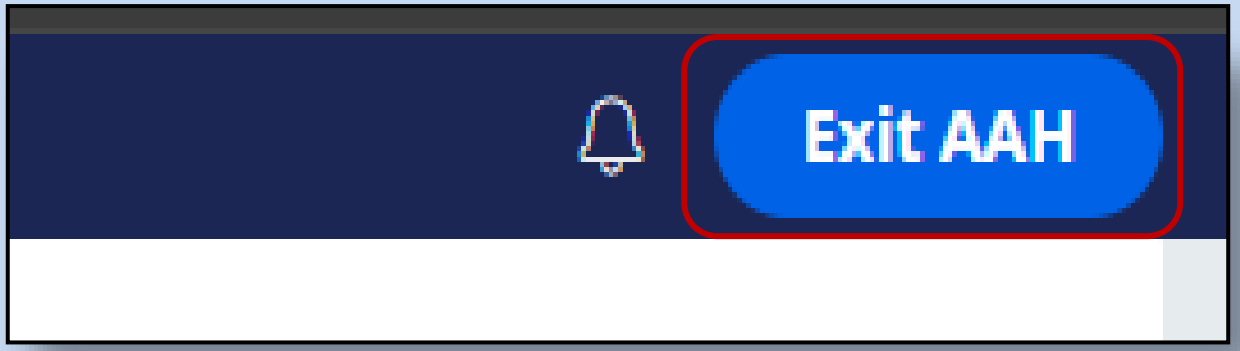
From here, users can select to submit another **Authorization Request**, or return to the Predictal home screen.



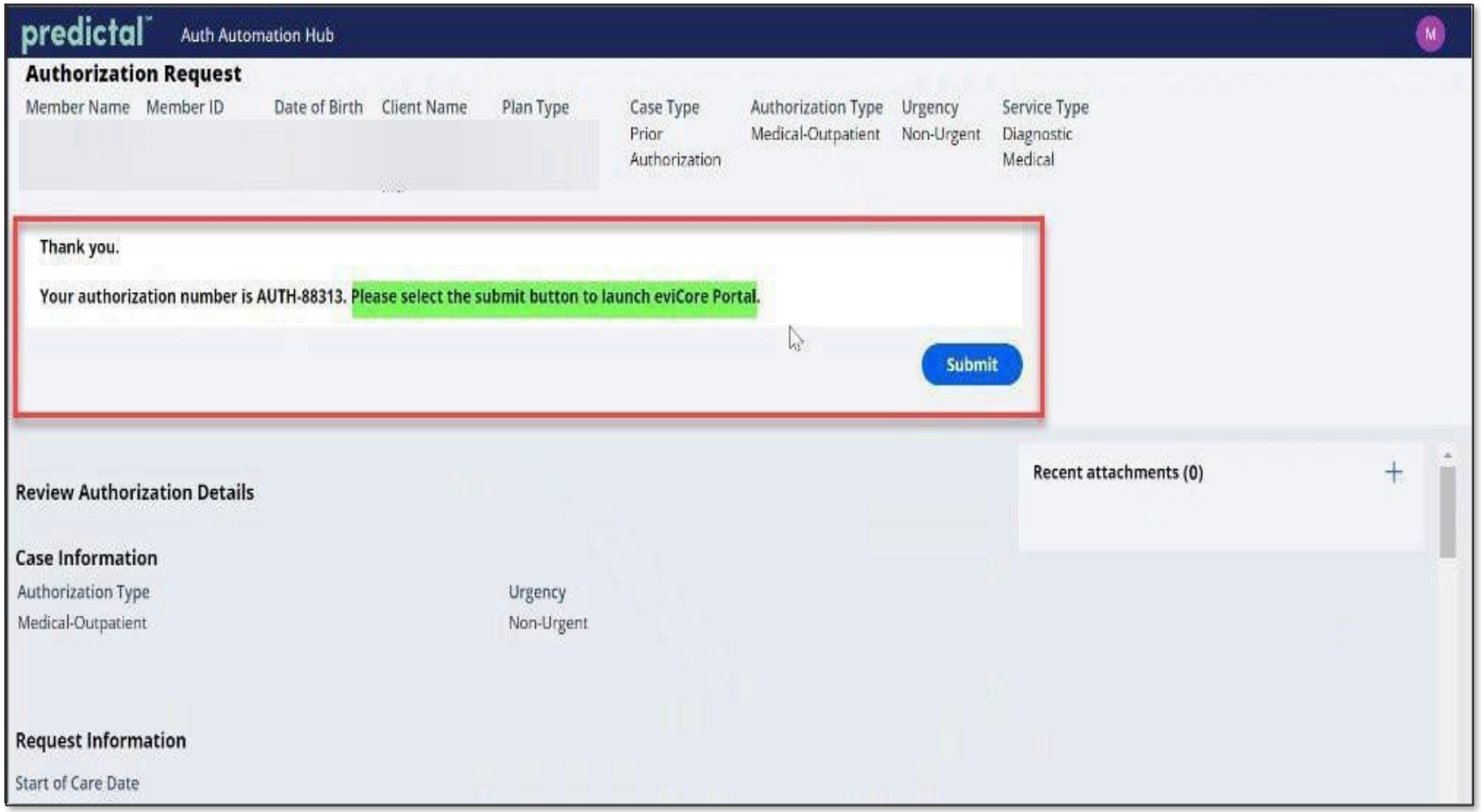
The screen below will be displayed when an authorization is auto-approved.



Note: When users are done in Predictal, officially exit the application by selecting the blue **EXIT AAH** button at the top right corner of the screen.

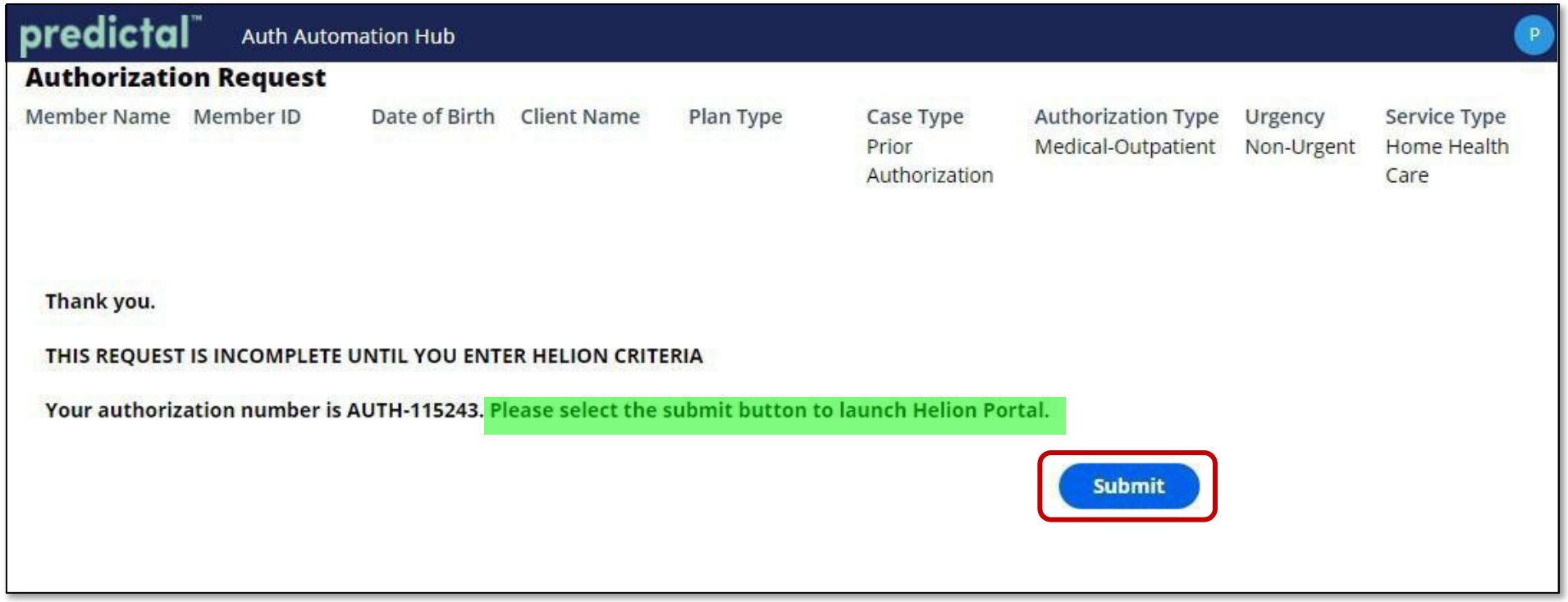


Please Note: When submitting an **eviCore-Managed Authorization**, be sure to click **Submit** to launch the **eviCore portal**.



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

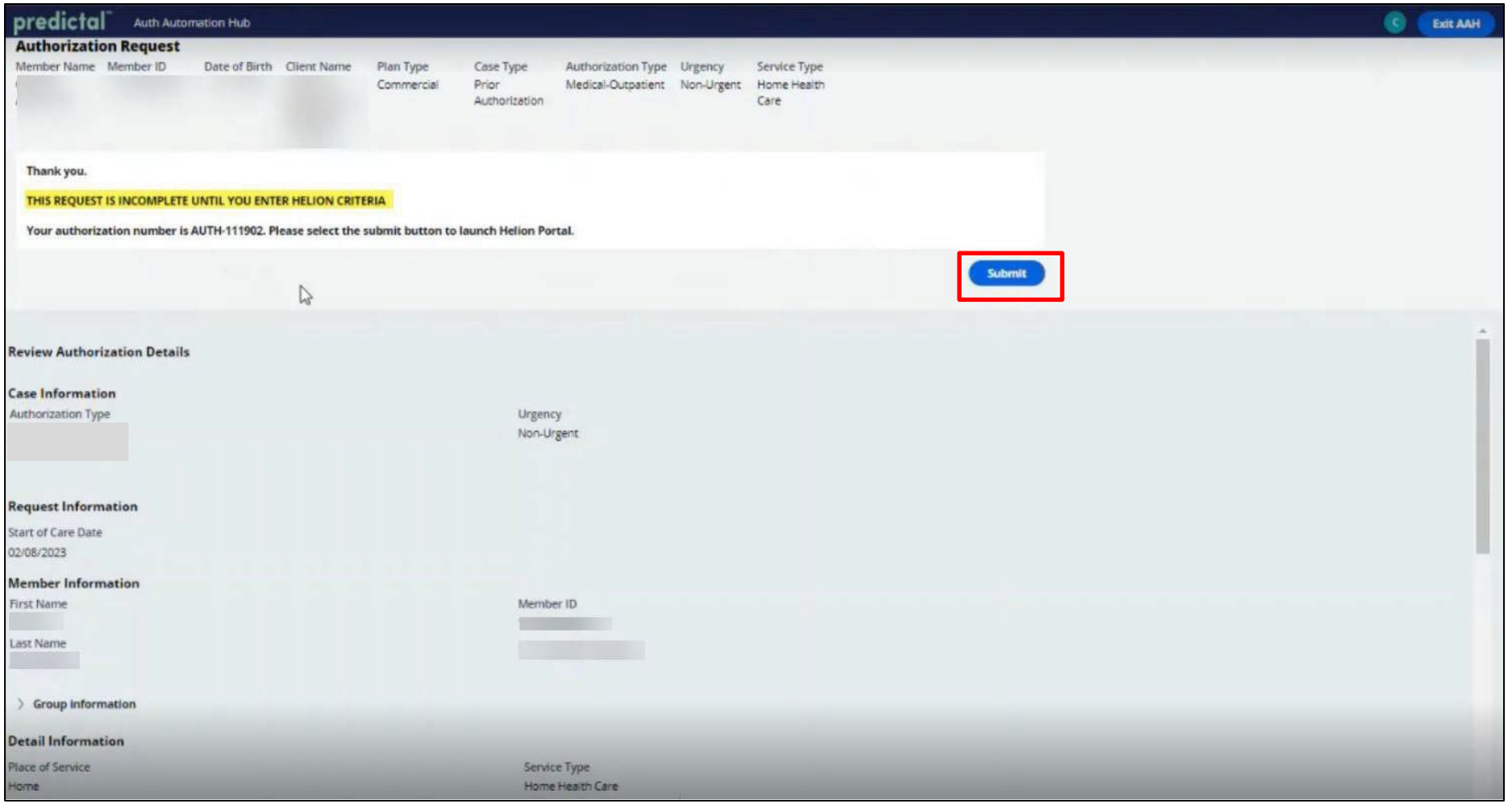
Additional information Helion Arc begins on the next page of this guide.



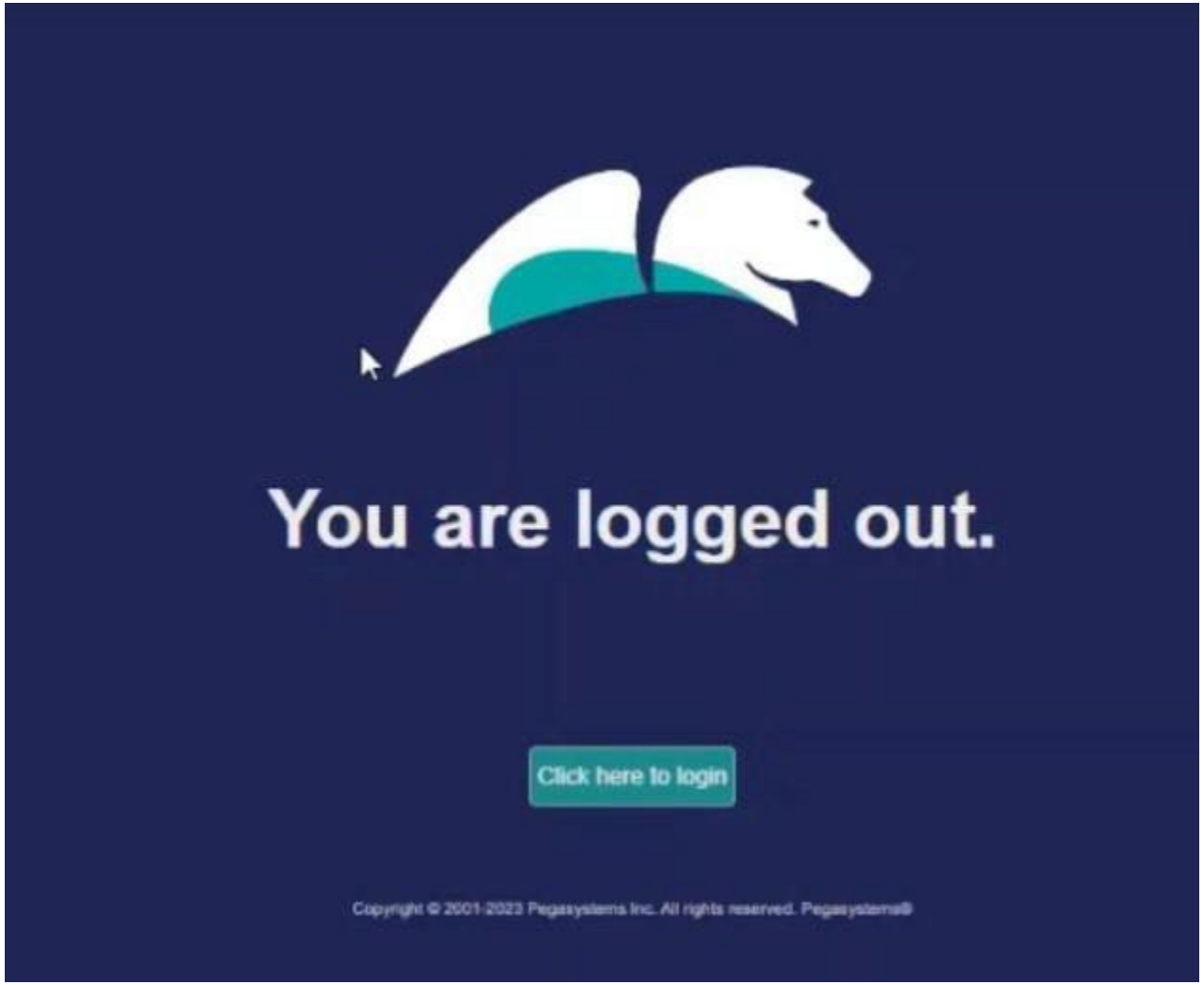
Helion Arc Authorization Submissions

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

Hit **Submit**.

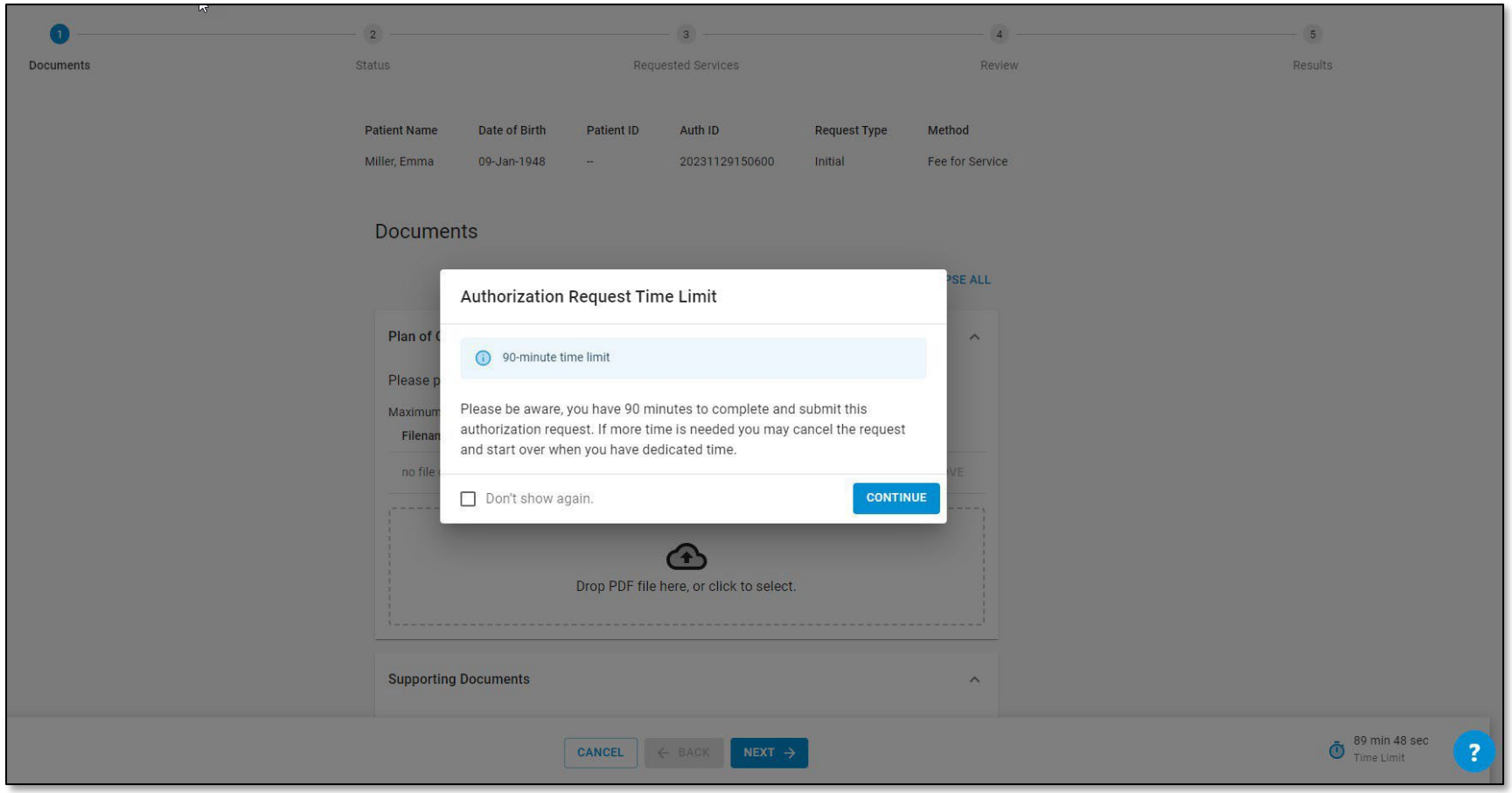


Users will be automatically logged out of the Predictal Auth Automation Hub and taken directly to Helion Arc.

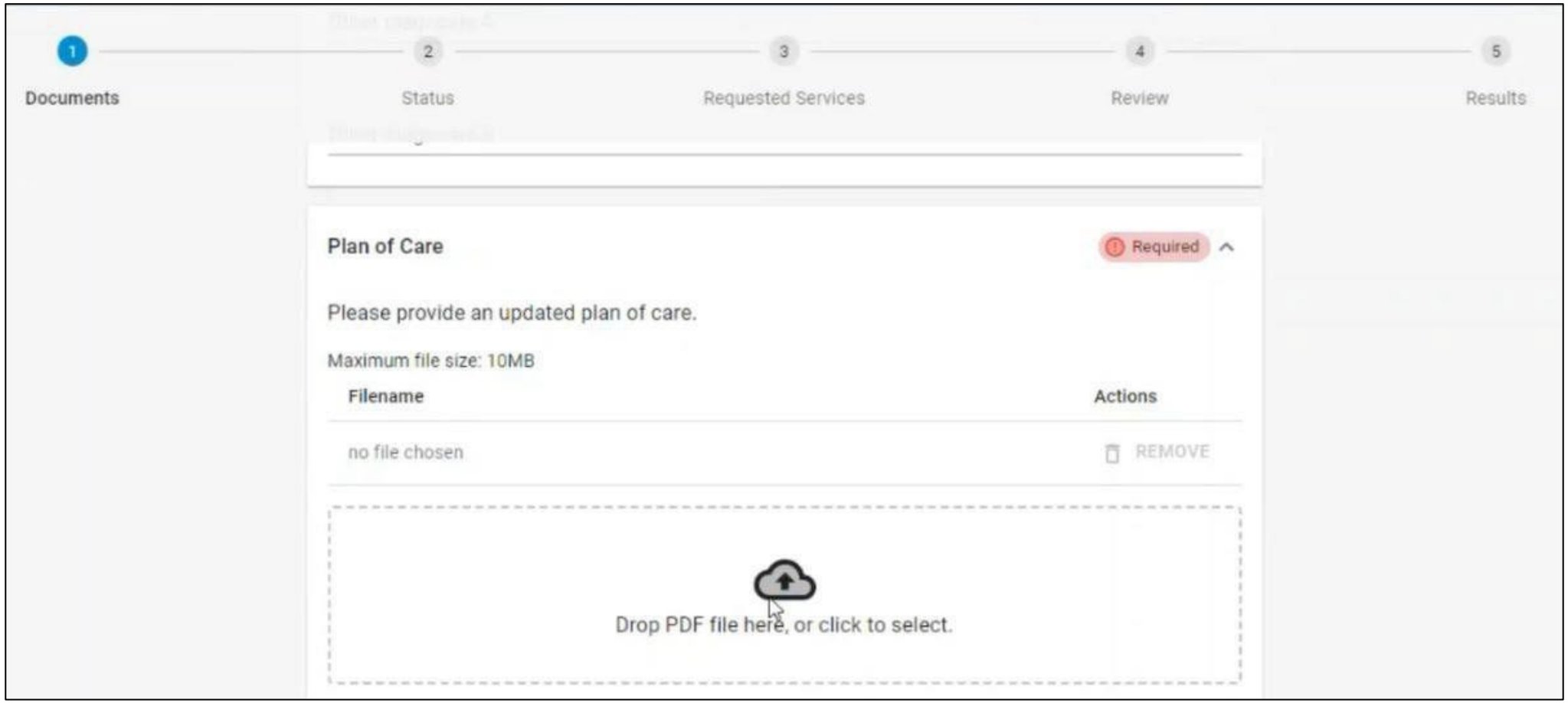


Once in Helion Arc, users will receive a message regarding the **Authorization Request Time Limit**, which indicates users have 90 minutes to complete and submit the authorization.

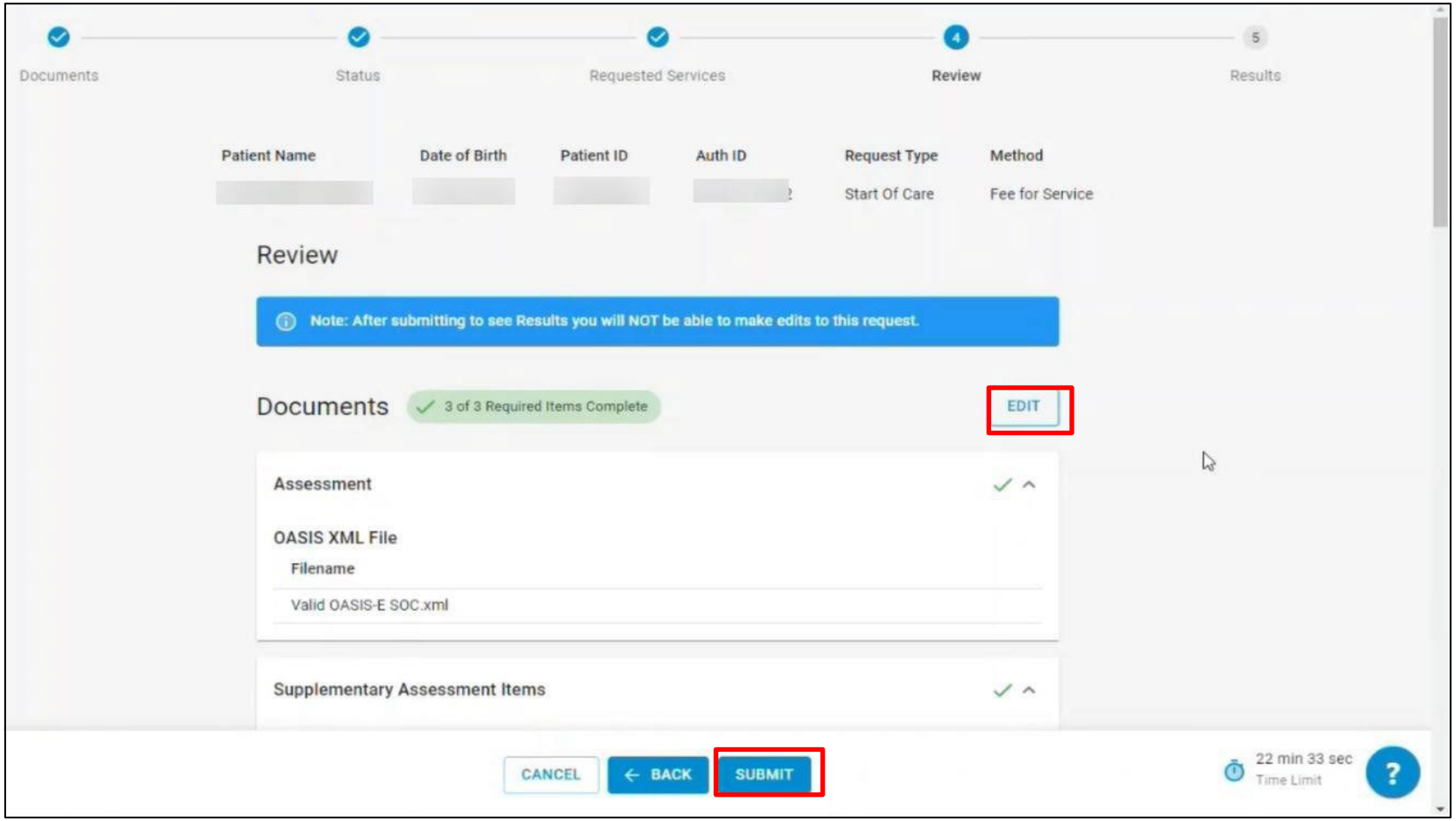
Click **Continue.** *(**Note:** The content may differ between requested services.)*



Users can upload the **Plan of Care**. This can be uploaded as a PDF file.



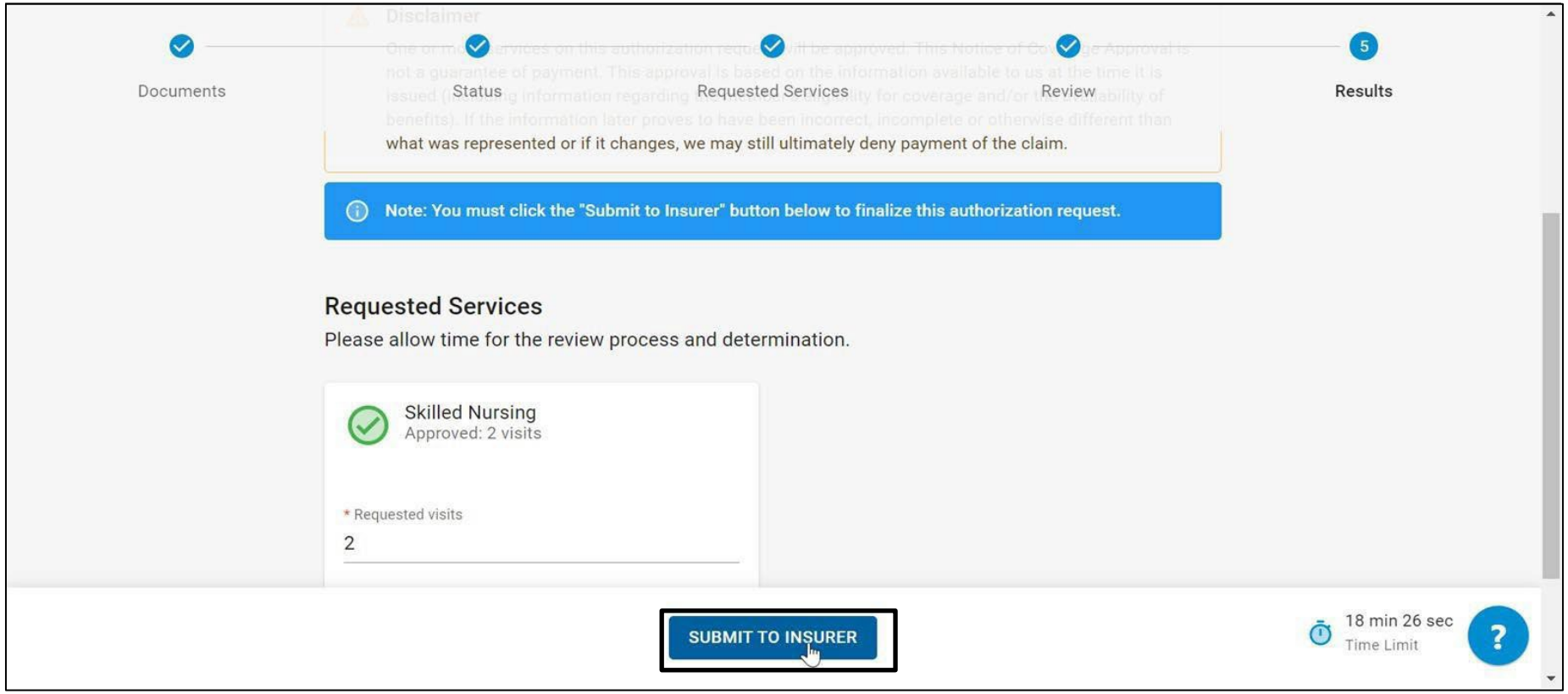
This is a review screen. Users can edit any information using the **Edit** buttons located in each section (scroll down to view). If all information looks correct, hit the blue **Submit** button.



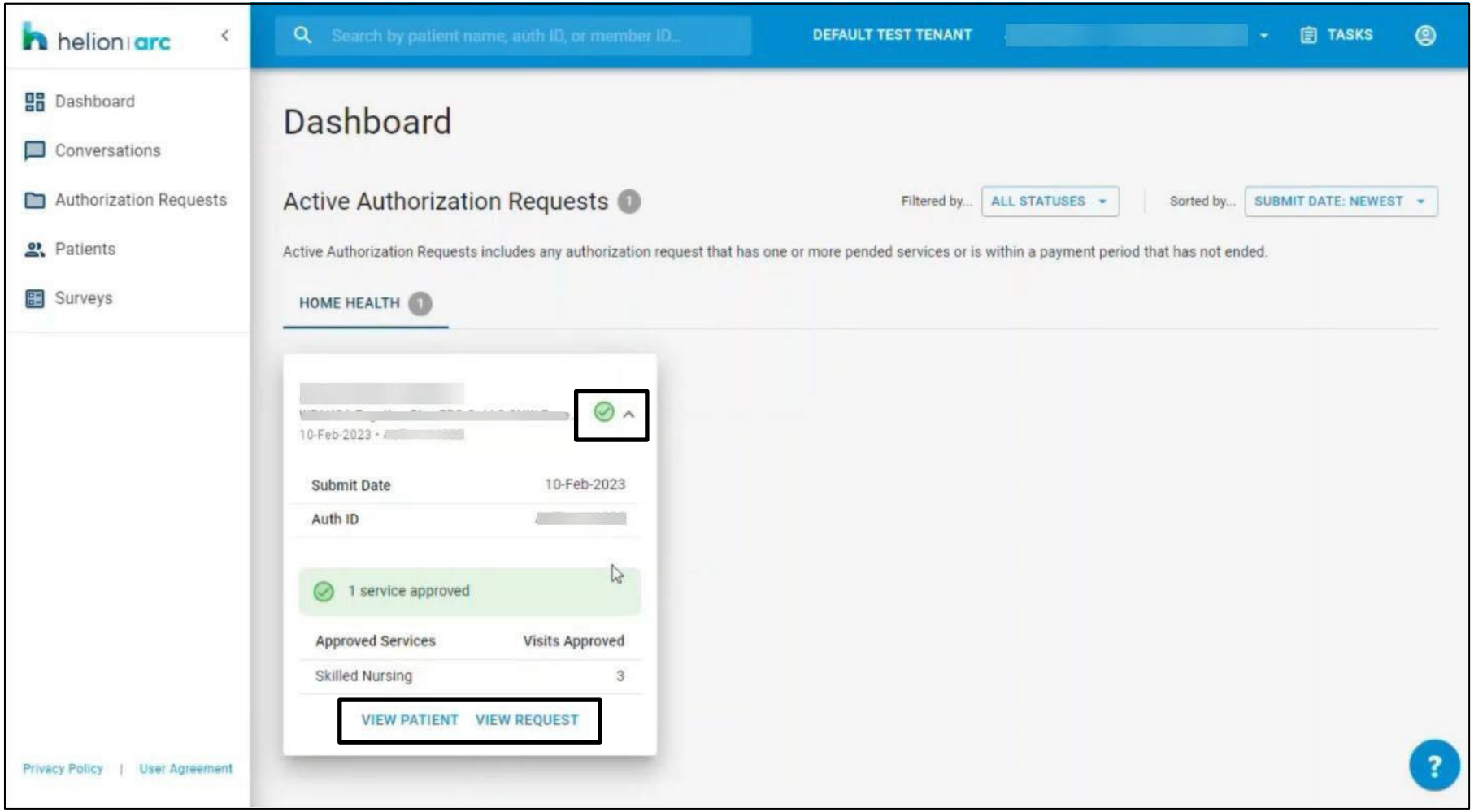
The request will be “Approved” or “Pended.”

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

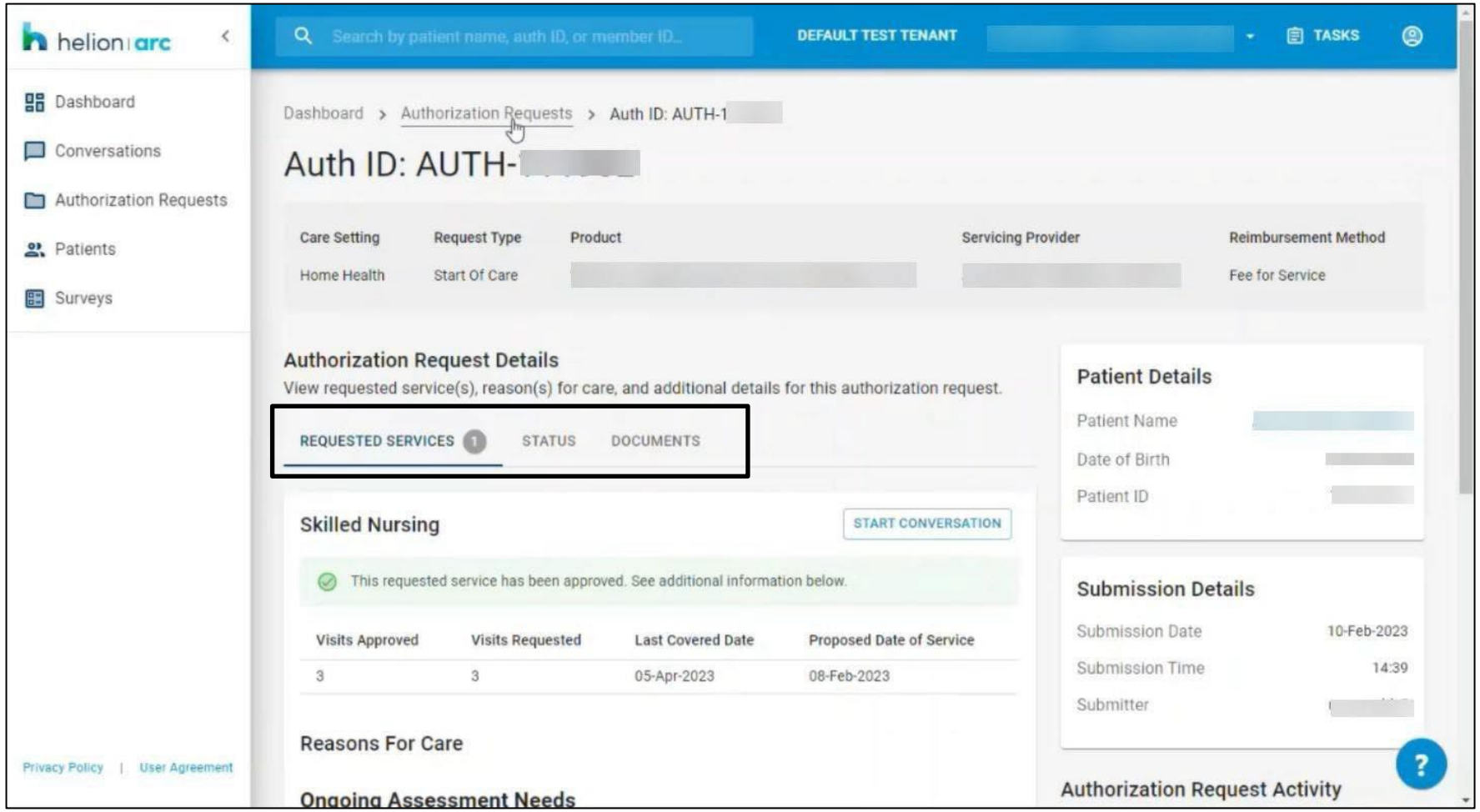
Click the blue **Submit to Insurer** button.



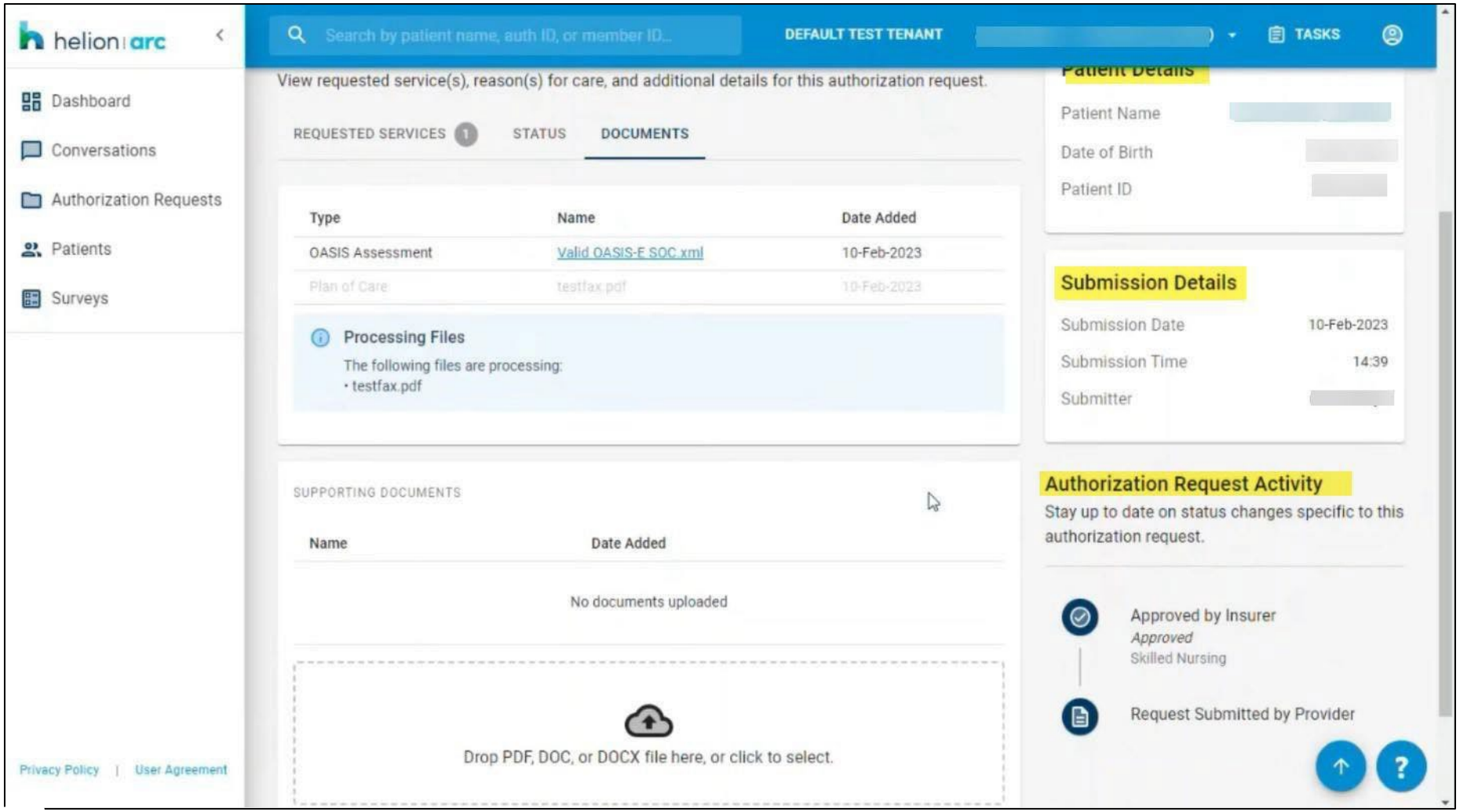
Users will be directed to the Helion Arc dashboard, where they can view active authorization requests. Clicking the arrow will open the **View Patient** and **View Request** information.



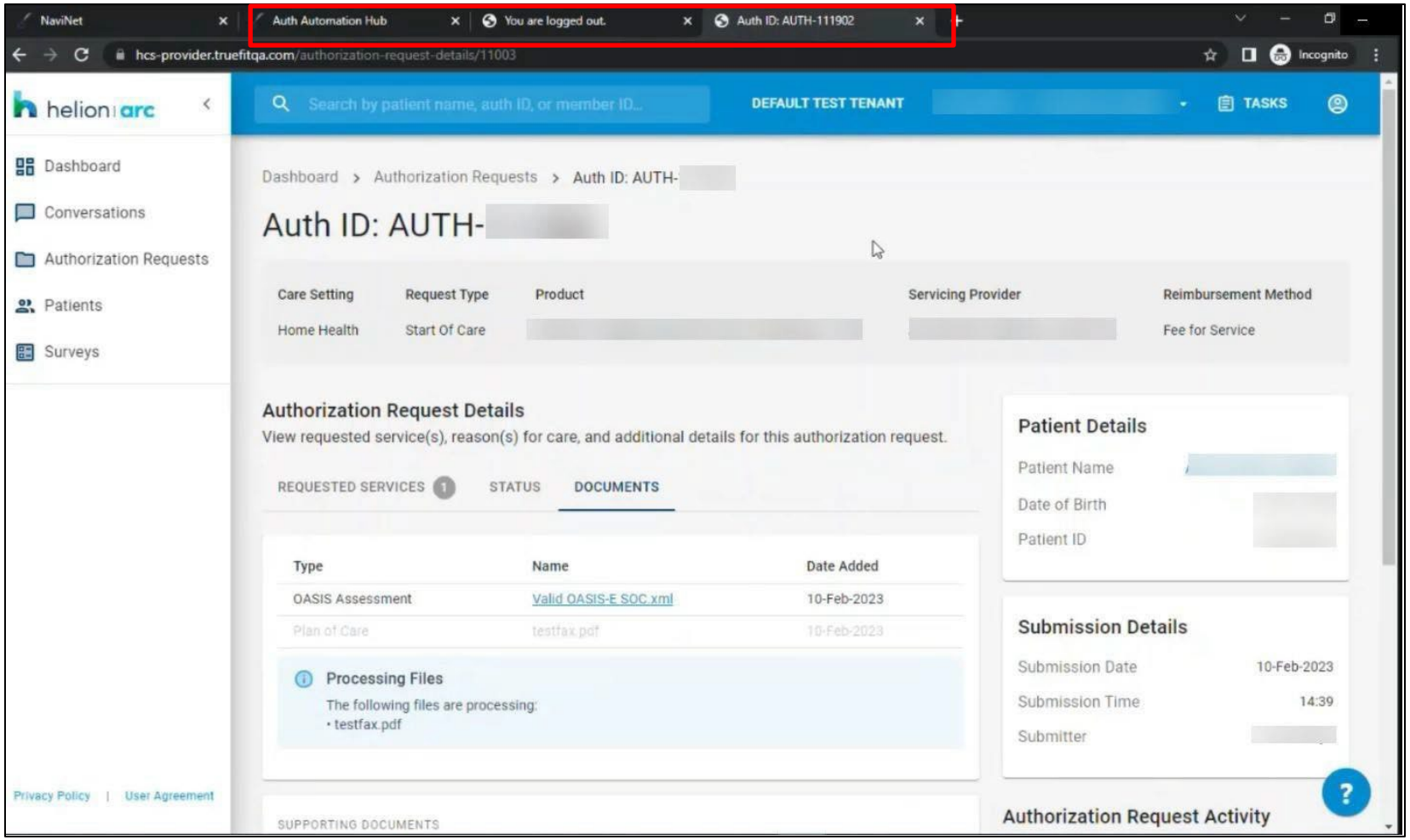
Clicking on either **View Patient** or **View Request** will open the **Authorization Request Details**. Users can see the Auth number at the top, as well as the **Requested Services**, **Status**, and any **Documents** that has been uploaded.



The panels on the right side of the screen show users **Patient Details**, **Submission Details**, and an audit history under **Authorization Request Activity**.



This completes the submission process for a request through Helion Arc.
Users can now close out of any browser tabs as needed using the **X** on each tab.



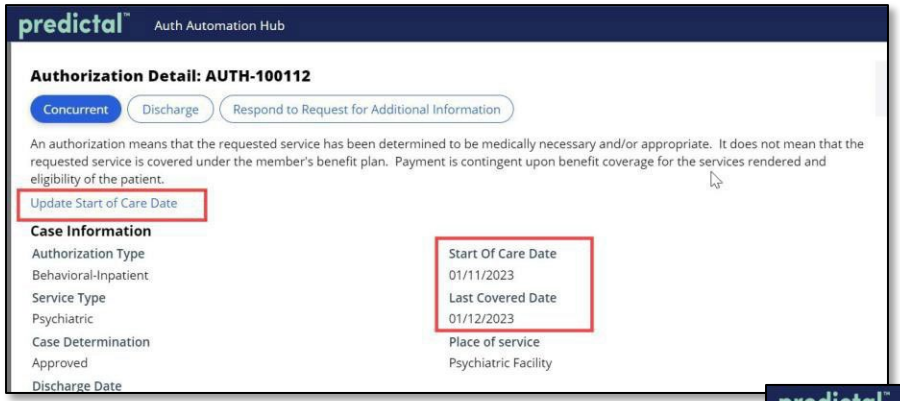
Availity Provider Portal
Predictal Authorization Inquiry

Change/Update Start of Care Date

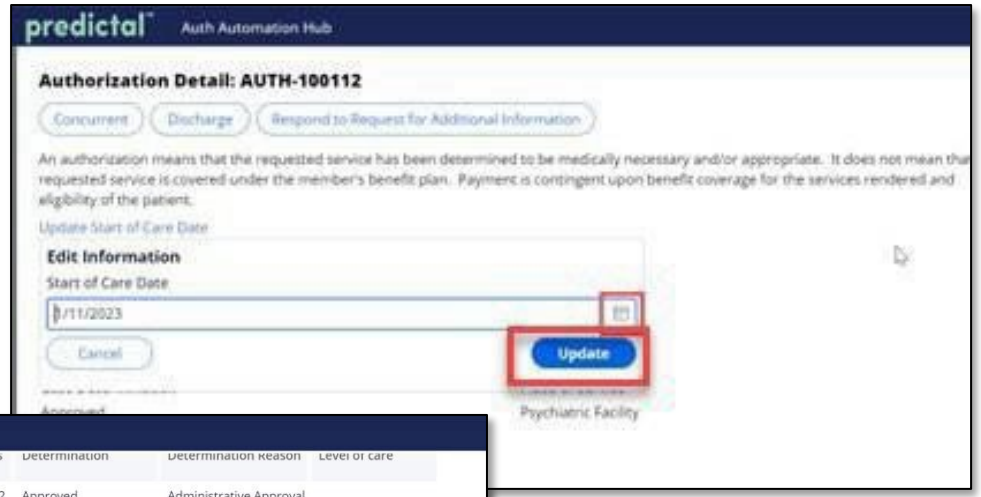
To update the **Start of Care Date** after the authorization is submitted:

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. Select the **Save Changes** button.

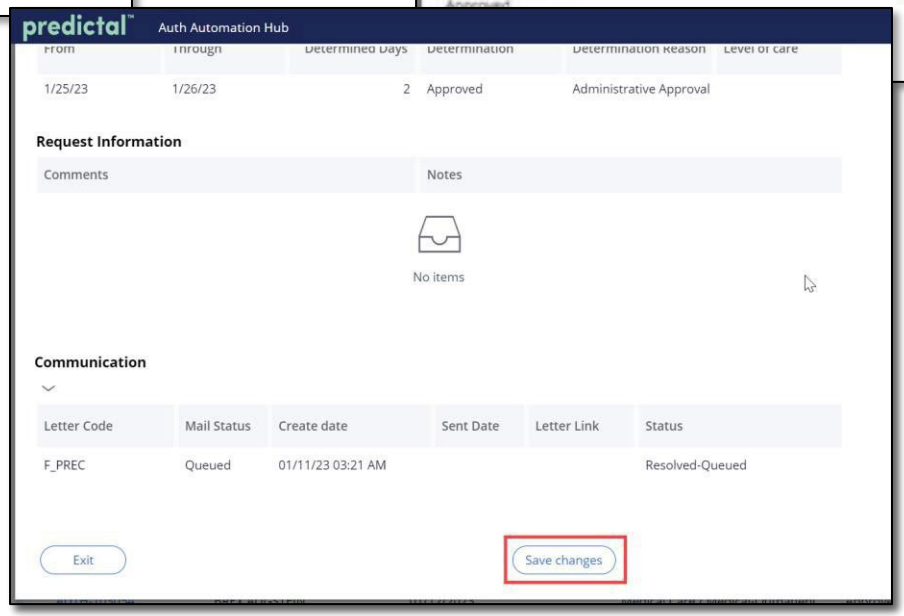
Step 1



Step 2



Step 3



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