

Availity® Provider Portal Outpatient Authorization Submissions

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

Web Browser Best Practices

Every **tab** you open consumes working memory (aka RAM), which can eventually lead to significant performance issues, so keeping the number of open tabs to a minimum is always in your best interest when using any web-based application.



When you use a browser, like Google Chrome™ or Microsoft Edge™, it saves some information from websites in its "cache" and "cookies". Clearing them fixes certain problems, like loading or formatting issues on sites.

YOU SHOULD KNOW...

Availity supports Google Chrome, Firefox® and Microsoft Edge v79, or higher



Be sure to allow for all pop-ups. Clearing your cache and cookies can also ensure the best user experience.

PFA/ Value Insights Center should only be accessed using Google Chrome browser.

Steps to clearing the cache

Google Chrome

1. Open your browser and click the  at the top right of the screen
2. Choose **Delete browsing data**
3. Click the **Advance** tab
4. Change time range to **"All time"**
5. Select the check boxes noted below, as desired:
 - Browsing history
 - Download history
 - Cookies and other site data
 - Cached images and files

Note: If the check box next to cookies and other site data is selected, you will be signed out of most websites.

6. Select **Clear Data**
7. Once the cache is cleared, close all open Chrome browsers, and then restart Chrome.

Microsoft Edge

1. Open your browser and click the  at the top right of the screen
2. Choose **Settings**
3. Choose **Privacy, search and services**
4. Scroll down to select **Clear browsing data now**
5. Click on **Choose what to clear**
6. Ensure **Cookies** and **Temporary Internet files** are marked

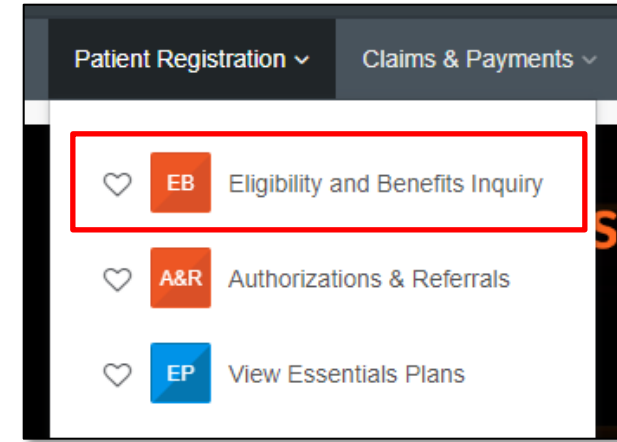
Note: If the check box next to cookies and other site data is selected, you will be signed out of most websites.

7. Select **Delete**

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.

A screenshot of the Availity 'Eligibility & Benefits' form. The form has a header with the 'EB' icon and the title 'Eligibility & Benefits', along with a 'Feedback' button. A yellow warning banner at the top states: 'To search for out of area members, use the Single Patient Search tab. Enter the facility or group NPI instead of the individual provider NPI.' Below this, a note says 'Fields marked with an asterisk * are required.' There are two dropdown menus: '* Organization' with 'Highmark PA Provider Test' selected, and '* Payer' with 'HIGHMARK BLUE SHIELD' selected. Below these is a section titled 'Provider Information' with a 'Clear Section' link. It contains a dropdown for 'Provider' and a search field with the text 'Search for a provider by name, NPI, tax ID, taxonomy code, or address'.

*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

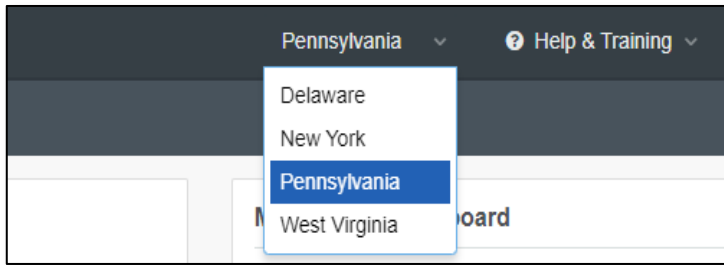
Also, refer to:

*<https://providers.highmark.com/claims-and-authorization/authorization-guidance/obtaining-authorizations>
on the Provider Resource Center (PRC).*

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

Next, choose the authorization path:

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



Path 1
Predictal via
Payer Spaces

Path 2
Authorizations and
Referrals

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

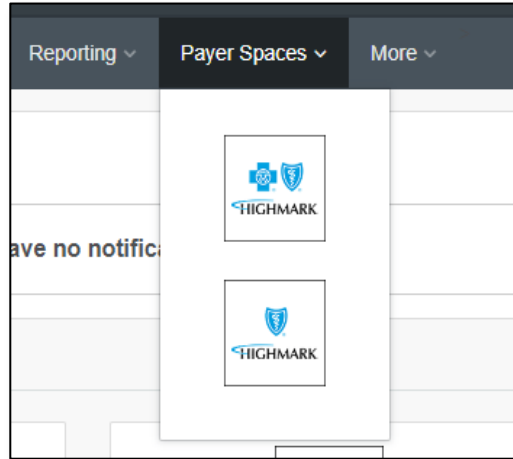
Exception 1:
Retail Pharmacy Authorization Submissions
Can ONLY Use Path 1

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

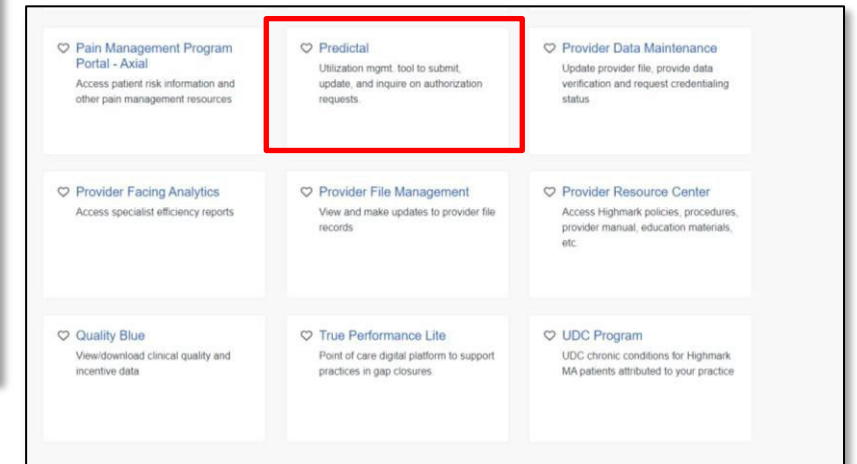
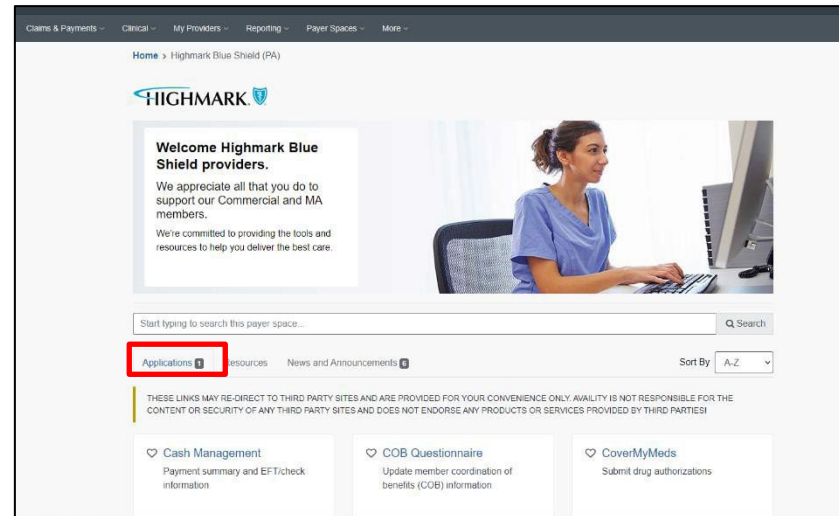
Path 1

To access Highmark's Payer Spaces in Avality 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).

Predictal

Select an Organization

Provider Org One

This field is required.

Select a Provider (Optional)

Provider Office One

Cancel Submit

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.

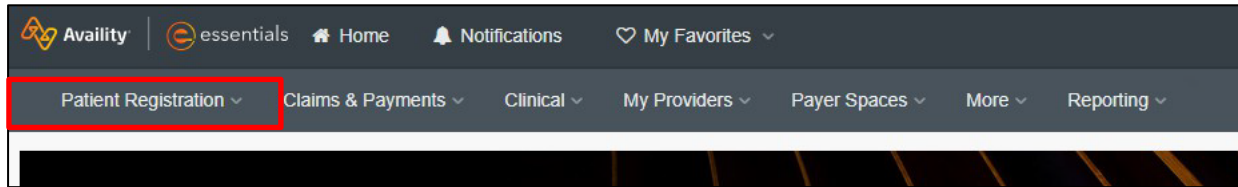
If users have multiple Tax IDs within the Organization within MMO, choose the Group (Type 2) NPI for the specific tax ID — NOT the individual Practitioner's (Type 1) NPI — in the **Select a Provider** drop-down menu.

- If you do not see your Group (Type 2) NPI in this list, or you chose a practitioner (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*.

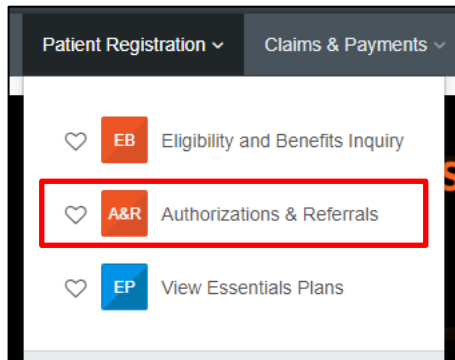
Path 2

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

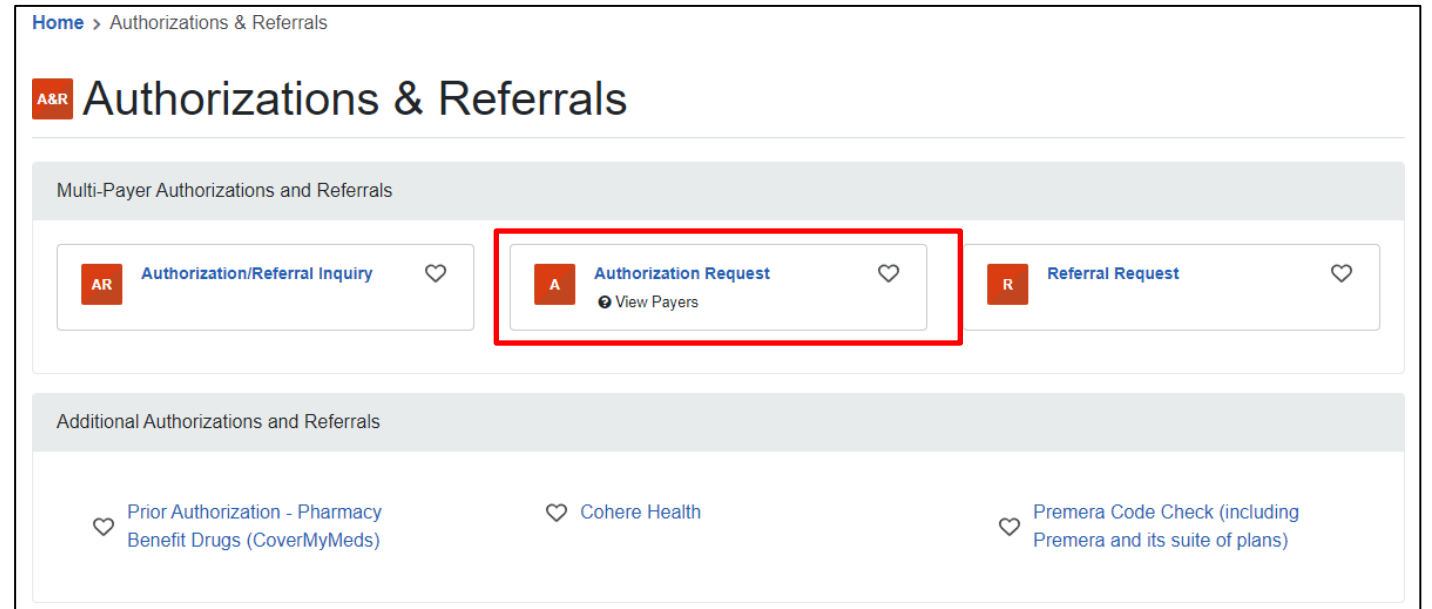
To access **Authorization & Referrals**, first click on **Patient Registration** from the main menu at the top of the screen.



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.

Home > Authorizations & Referrals > Authorizations Need help? Watch a demo about Authorizations and Referrals.

Authorizations Give Feedback New Request

SELECT A PAYER

Organization •
Highmark

Template(s) optional [Manage Templates](#)
No template selected

Select a template from the list or continue with Payer and Request Type fields.

Payer •
Select a Payer

Request Type •
Select Authorization Type

Next

v7.403.3

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.

Home > Authorizations & Referrals > Authorizations Need help? Watch a demo about Authorizations and Referrals.

Authorizations Give Feedback Go to Dashboard New Request

SELECT A PAYER

Organization •
Buffalo General Hospital

Template(s) optional [Manage Templates](#)
No template selected

Select a template from the list or continue with Payer and Request Type fields.

Payer •
Select a Payer

Request Type •
Select Authorization Type

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 practitioner (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.

predictal™ Auth Automation Hub Exit AAH

Highmark Welcomes

Helpful Links


- List of Procedures and DME Requiring Authorization
- List of FEP Standard and Basic Procedures Requiring Prior Approval
- List of FEP Blue Focus Procedures and DME Requiring Prior Approval
- Request a prescription drug authorization request through CoverMyMeds

Information you will need to submit an authorization:

- Member Demographics
- Procedure/Service Details
- Diagnosis Details
- Provider Details
- Clinical Criteria

[New Auth Submission](#)

My Unsubmitted Auths

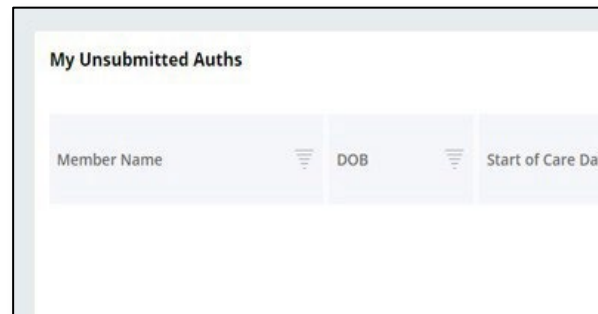
Member Name	DOB	Start of Care Date	Authorization Type	Service Type	Last updated by	Actions
 No Items						

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:

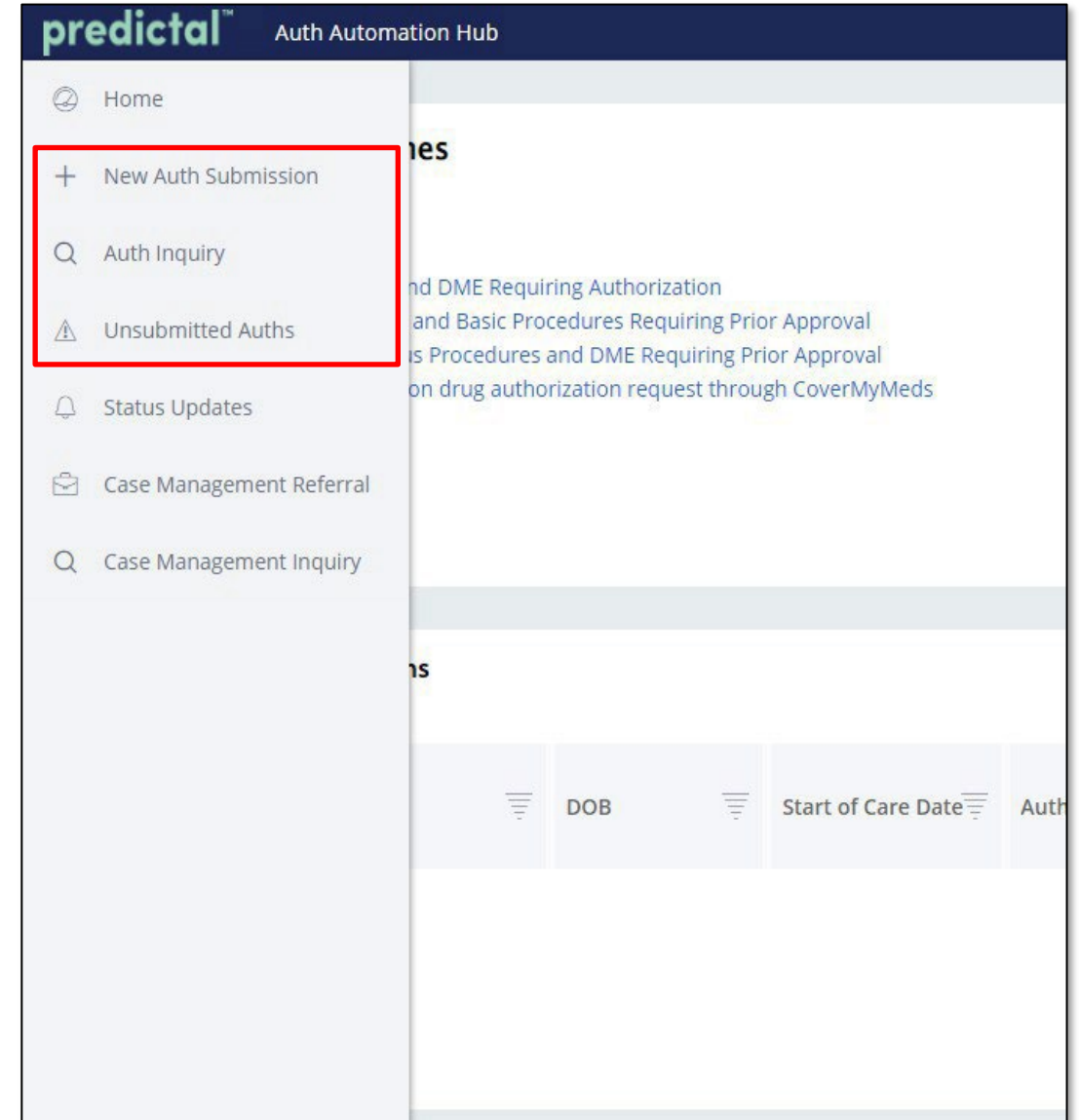
1. Check Authorization Status
2. Review Approval and Denial Letters
3. Discharges
4. Concurrent
5. Respond to a Request For Additional Information
6. Extension

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.



My Unsubmitted Auths		
Member Name	DOB	Start of Care Date



predictal™ Auth Automation Hub

- Home
- New Auth Submission
- Auth Inquiry
- Unsubmitted Auths
- Status Updates
- Case Management Referral
- Case Management Inquiry

Auth Automation Hub

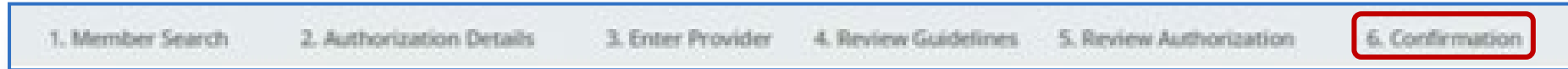
and DME Requiring Authorization
and Basic Procedures Requiring Prior Approval
is Procedures and DME Requiring Prior Approval
on drug authorization request through CoverMyMeds

Auth

DOB Start of Care Date

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**.



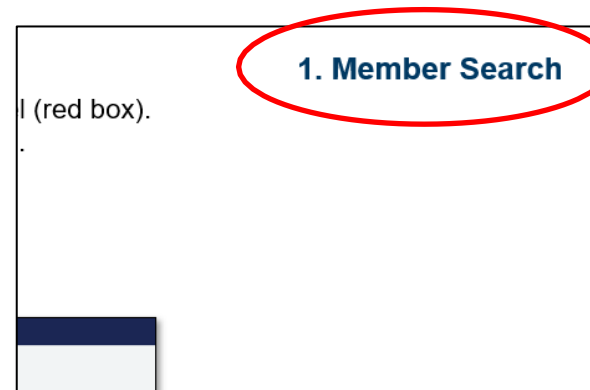
After each step listed in the top menu bar, users will be prompted to hit **Submit**. The authorization will not be submitted to Highmark until the *final Submit* on the **Confirmation** screen is selected (*Step 6 above.*)

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).

The screenshot shows the Predictal Auth Automation Hub interface. The top navigation bar includes the Predictal logo and 'Auth Automation Hub'. The main header is 'Authorization Request'. Below this is a table with columns: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type, Authorization Type, and Service Type. A red box highlights a '+' icon in the left navigation panel. The main content area is titled 'Ordering/Attending Provider' and contains a 'Select provider *' dropdown menu. Below this is a warning icon and text: 'To select a member, click on the search results table to expand the desired member. Then, highlight the correct Group Number/LOB row to select and continue'. The 'Search' section has a 'Search For' dropdown set to 'Member'. It includes a 'Search for member *' field with a 'Member ID' dropdown, a 'Start of Care Date *' field with a date picker set to '11/30/2023', and a 'Member UMI *' field. A blue 'Search' button is located below these fields. The search results show 'Search Result: 4 matches found...' and a table with columns: Member ID, First Name, Last Name, Date of Birth, and Gender. One row is visible with the date of birth '07/20/1985' and gender 'FEMALE'.

1. Member Search

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.

The screenshot displays a web interface for member search. At the top, there is a radio button labeled "Member". Below it are search filters: "Search for member *" with a dropdown menu showing "Member ID", and "Start of Care Date *" with a date input field showing "11/30/2023". There is also a "Member UMI *" input field and a blue "Search" button. Below the search filters, it says "Search Result: 4 matches found...". The results are shown in a table with two columns: the top column shows member details (Member ID, First Name, Last Name, Date of Birth, Gender) and the bottom column shows policy details (UMI, Client Name, Group Name, Group Number, LOB, COB, Start Date, End date, Relationship). Two red arrows point to the first row of the top table and the first row of the bottom table.

Member ID	First Name	Last Name	Date of Birth	Gender
[REDACTED]	[REDACTED]	[REDACTED]	07/20/1985	FEMALE

UMI	Client Name	Group Name	Group Number	LOB	COB	Start Date	End date	Relationship
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	PPO	[REDACTED]	01/01/2021	[REDACTED]	EMPLOYEE

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**

predictal Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
				Commercial	Prior Authorization	Medical-Outpatient	---

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

Case Information

Authorization Type *

Medical-Inpatient

Medical-Outpatient

Behavioral-Inpatient

Behavioral-Outpatient

Pharmacy

Case Type

Prior Authorization

Request Information

Start of Care Date *

10/31/2023

Member Information

First Name

Select...

Ambulance - Ambulance - Air or Water

Ambulance - Land

Ambulatory Surgical Center

Birth Center

Comprehensive Outpatient Rehabilitation Facility

Home

Independent Clinic

Independent Laboratory

Office

Outpatient Hospital

Professional Ambulatory Infusion Suite

Outpatient Hospital

Select...

Anesthesia

Cardiac Rehabilitation

Consultation

Diagnostic Lab

Diagnostic Medical

Diagnostic X-Ray

Dialysis

Durable Medical Equipment

Infertility

Infusion Therapy

Inhalation Therapy

Injectable Drug

In-vitro Fertilization

Maternity

Medical Care

Medically Related Transportation

MRI/CAT Scan

Oral Surgery

Pharmacy

Select...

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

predictal™ Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
[Redacted]	[Redacted]	1[Redacted]	[Redacted]	Commercial	Prior Authorization	Medical-Outpatient	---

Detail Information

Place of Service * Service Type *

Diagnosis Information

Code Set Type *	Code *	Description *	
<input type="text" value="ICD 10"/>	<input type="text" value="Enter Code/Description"/>	---	<input type="button" value="Remove"/>

Add

Procedure Information

Code Set Type *	Code *	Description *	
<input type="text" value="Select..."/>	<input type="text" value="Enter Code/Description"/>	---	

From * Requested units * Unit Type *

Add

2. Authorization Details

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).

Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
					Prior Authorization	Medical-Outpatient	Medical Care

Diagnosis Information

Code Set Type *	Code *	Description *
ICD 10 v	I83.	
	I83.209	VARICOSE VEINS OF UNSPECIFIED LOWER EXTREMITY WITH BOTH ULCER OF UNSPECIFIED SITE AND INFLAMMATION
	I83.211	VARICOSE VEINS OF RIGHT LOWER EXTREMITY WITH BOTH ULCER OF THIGH AND INFLAMMATION
	I83.212	VARICOSE VEINS OF RIGHT LOWER EXTREMITY WITH BOTH ULCER OF CALF AND INFLAMMATION
	I83.213	VARICOSE VEINS OF RIGHT LOWER EXTREMITY WITH BOTH ULCER OF ANKLE AND INFLAMMATION
	I83.214	

Procedure Information

Code Set Type *	Code *
CPT v	Enter Code

From *
12/4/2023

2. Authorization Details

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.

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
				Commercial	Prior Authorization	Medical-Outpatient	---

Place of Service * Service Type *

Diagnosis Information

Code Set Type *	Code *	Description *	
<input type="text" value="ICD 10"/>	<input type="text" value="I83.001"/>	VARICOSE VEINS OF UNSPECIFIED LOWER EXTREMITY WITH BOTH ULCER OF UNSPECIFIED SITE AND INFLAMMATION	<input type="button" value="Remove"/>

Procedure Information

Code Set Type *	Code *	Description *
<input type="text" value="Select..."/>	<input type="text" value="Enter Code/Description"/>	---

From *	Requested units *	Unit Type *	
<input type="text" value="12/4/2023"/>	<input type="text"/>	<input type="text" value="Select..."/>	<input type="button" value="Remove"/>

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.

The screenshot displays the 'predictal Auth Automation Hub' interface. At the top, it shows 'Authorization Request' with fields for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type (Medical-Outpatient), Urgency (Non-Urgent), and Service Type (Medical Care). Below this is a table for procedure codes with columns for Code Set Type (dropdown), Code (dropdown), and Description. One entry is visible: ICD-10, B42.82, SPOROTRICHOSIS ARTHRITIS, with a 'Remove' button. Underneath is the 'Procedure Information' section, which includes a disclaimer and a form for adding new codes. This form has fields for Code Set Type (dropdown with CPT and HCPCS options), Code (text input), Description (text input), Requested units (text input), and Unit Type (dropdown). There are 'Add' and 'Remove' buttons. At the bottom, there are sections for 'Indicate Location of Clinical Information' and 'Submitter Contact Information', each with an 'Add' button.

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

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

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

The screenshot shows the 'Authorization Request' form. At the top, there is a header with fields for Member Name, Member ID, Date of Birth, Client Name, Plan Type (Commercial), Case Type (Prior Authorization), Authorization Type (Medical-Outpatient), and Service Type. Below this is a progress bar with five steps: 1. Member Search, 2. Authorization Details (current), 3. Enter Provider, 4. Review Authorization, and 5. Confirmation. The main content area is divided into 'Case Information' and 'Request information'. 'Case Information' includes radio buttons for Authorization Type: Medical-Inpatient, Medical-Outpatient (selected), Behavioral-Inpatient, Behavioral-Outpatient, and Pharmacy. 'Request information' includes a 'Start of Care Date' field with the value 12/04/2023. On the right side, there is a 'Tools' section with a 'History' link and a 'Recent attachments (0)' section. The 'Recent attachments (0)' section is highlighted with a red box and contains two buttons: 'Attach File' and 'Attach URL', with a plus icon to the right.

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

The screenshot shows the 'Attach file(s)' dialog box. It has a title bar with a close button. The main area contains a dashed box with a paperclip icon and the text 'Drag and drop files here'. Below this is the text 'OR' and a blue button labeled 'Select file(s)'. At the bottom, there are 'Cancel' and 'Attach' buttons.

The screenshot shows the 'Attach a link' dialog box. It has a title bar with a close button. The main area contains a 'Name *' field with a red error message 'Value cannot be blank' below it. Below the name field is a 'URL *' field. Underneath is an 'Attachment Category' dropdown menu with a list of options: URL (selected), DOC, DOCX, JPG, PDF, PNG, PPT, PPTX, TXT, URL, XLS, and XLSX. A blue 'Submit' button is located at the bottom right.

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.

predical Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Outpatient	Non-Urgent	Medical Care

Diagnosis Information

Code Set Type	Code	Description	
ICD-10	B42.82	SPOROTRICHOSIS ARTHRITIS	Remove

Add

Procedure Information

CPT/HCPCS Disclaimer: Current Procedural Terminology (CPT) is copyright 2021 American Medical Association. All rights reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. Current Dental Terminology © American Dental Association. All rights reserved. Service provider acknowledges that the information being provided is based on data currently available. Processing of all claims is subject to medical policy, a determination of the member's benefit program and eligibility at the time of service.

Code Set Type	Code	Description
CPT	3647	

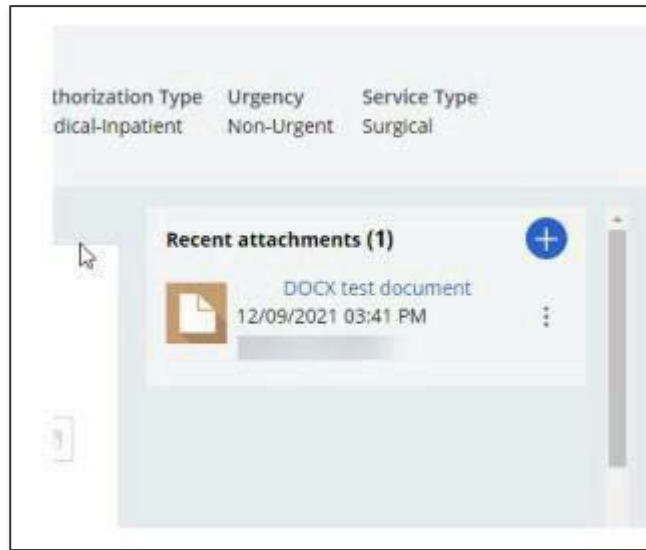
From: 33647
11/24/2022 REPAIR OF ATRIAL SEPTAL DEFECT AND VENTRICULAR SEPTAL DEFECT, WITH DIRECT ORATCH CLOSURE

Add

36470	INJECTION OF SCLEROSANT, SINGLE INCOMPETENT VEIN (OTHER THAN TELANGIECTASIA)
36471	INJECTION OF SCLEROSANT, MULTIPLE INCOMPETENT VEINS (OTHER THAN TELANGIECTASIA) SAME LEG
36473	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS MECHANOCHEMICAL, FIRST VEIN TREATED
36474	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS MECHANOCHEMICAL, SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO C00)
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS RADIOFREQUENCY, FIRST VEIN TREATED
36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS RADIOFREQUENCY, SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO C00)
36478	
36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS LASER, FIRST VEIN TREATED

Remaining: 234 (130)

(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**.

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type Commercial	Case Type Prior Authorization	Authorization Type Medical-Outpatient	Service Type ---
-------------	-----------	---------------	-------------	-------------------------	-------------------------------------	--	---------------------

Indicate Location of Clinical Information
[Add](#)

Submitter Contact Information

Contact Name *	Phone Number *	Ext.
<input type="text"/>	<input type="text" value="###) ###-####"/>	<input type="text"/>

Please enter any additional information *

If clinical documentation is not added as an attachment, please include the relevant clinical documentation here.
If clinical documentation is added as an attachment, please indicate so here.

Remaining: 8000 characters

[Back](#) [Save](#) [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.

predictal Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
				Commercial	Prior Authorization	Medical-Outpatient	Non-Urgent	Medical Care

1. Authorization Details 2. Enter Provider 3. Review Authorization 4. Confirmation

To select a provider, click on the search results table to expand the facility/vendor and then highlight the correct address to select.

Provider Details

Ordering/Attending Practitioner

1 match found

Practice Group NPI	Practice Group Name	Practitioner NPI	Practitioner Name	Practitioner City	Prac. State	Prac. Zip Code
XXXXXXXXXX	Family Practice	XXXXXXXXXX	Dr Smith	City	PA	15212

Copy as Servicing Facility/Vendor Copy as Performing Provider

Servicing Facility/Vendor

Search for

Recent attachments (0)

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.)

The screenshot shows the 'Authorization Request' form with the following details:

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
[Redacted]	[Redacted]	[Redacted]	[Redacted]	Commercial	Prior Authorization	Medical-Outpatient	Medical Care

Servicing Facility/Vendor

Search for

Facility / Vendor

Search by

Provider ID Name

Search for

NPI or BSID

NPI or BSID

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.)

The screenshot shows the 'Authorization Request' form with the following details:

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
[Redacted]	[Redacted]	[Redacted]	[Redacted]	Commercial	Prior Authorization	Medical-Outpatient	Medical Care

Performing Provider

Search for

Practitioner Practice Group

Search by

Provider ID Name

NPI or BSID

Authorization Request Submitted By *

Select... ▾

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..**

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
				Commercial	Prior Authorization	Medical-Outpatient	Medical Care

Facility / Vendor NPI	Facility / Vendor Name	Facility / Vendor Address	Facility / Vendor City	State	Zip code
	NON PA PHARMACY	HIGHMARK BLUE SHIELD	CAMP HILL	PA	17011

Addresses

Tax ID	BSID
****4723	000204107

Address type	Facility / Vendor Address	Facility / Vendor City	State	Zip code	Contact Details
Main	HIGHMARK BLUE SHIELD	CAMP HILL	PA	17011	Phone (717) 999-9999 Primary

Vendor	HIGHMARK BLUE SHIELD	CAMP HILL	PA	17011	Phone (717) 999-9999 Primary
--------	----------------------	-----------	----	-------	------------------------------

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.

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
				Commercial	Prior Authorization	Medical-Outpatient	Medical Care

Performing Provider

Search for

Practitioner Practice Group

Search by

Provider ID Name

NPI or BSID

Authorization Request Submitted By *

Select...

Value cannot be blank

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.

The screenshot displays the 'Auth Automation Hub' interface for an 'Authorization Request'. The form contains the following fields and options:

- Member Name**, **Member ID**, **Date of Birth**, **Client Name**, **Plan Type**
- Case Type**: Prior Authorization
- Authorization Type**: Medical-Inpatient
- Urgency**: Non-Urgent
- Service Type**: Medical Care
- Search for**:
 - NPI or BSID
 - Tax ID
- NPI or BSID**: [Text Input Field] **Search** button
- Authorization Request Submitted By *** dropdown menu:
 - Select...
 - Select...
 - Ordering/Attending Practitioner
 - Servicing Facility/Vendor
 - Performing Provider
- Back** button and **Submit** button

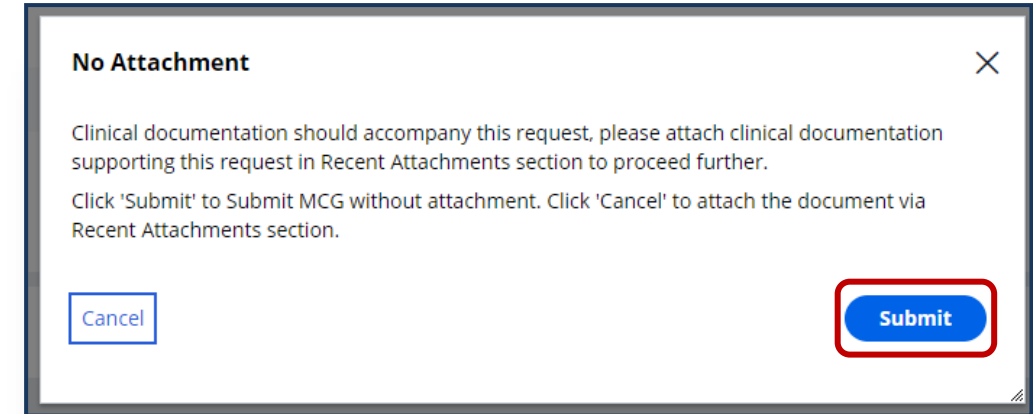
Invoking MCG Criteria

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.*

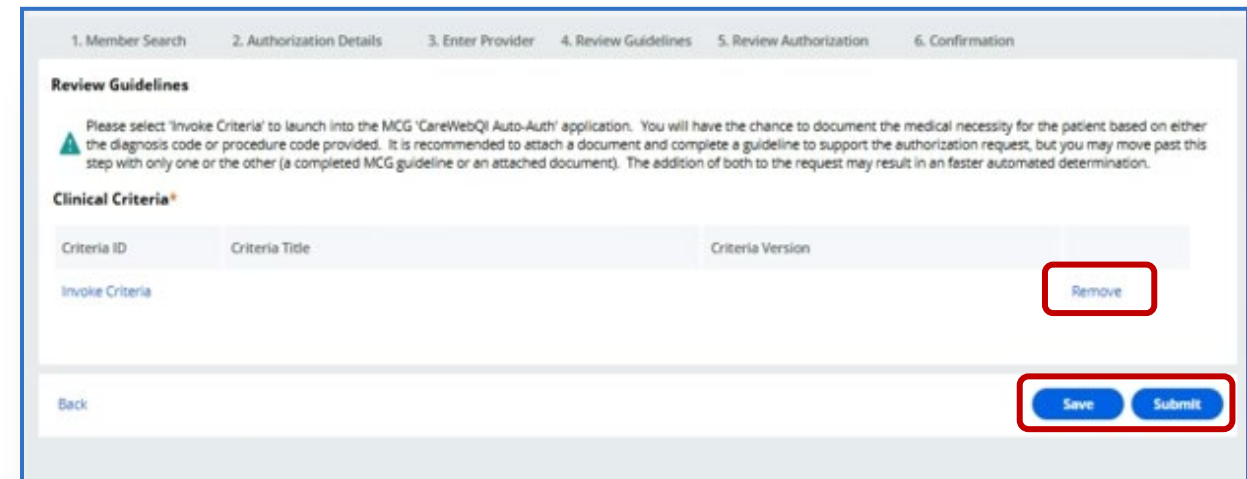
Bypass for Attaching Clinical Documentation

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

The screenshot shows a web interface for the 'Review Guidelines' step. At the top, a progress bar indicates six steps: 1. Member Search, 2. Authorization Details, 3. Enter Provider, 4. Review Guidelines (highlighted with a red box), 5. Review Authorization, and 6. Confirmation. Below the progress bar, the 'Review Guidelines' section contains a warning icon and text: 'Please select 'Invoke Criteria' to launch into the MCG 'CareWebQI Auto-Auth' application. You will have the chance to document the medical necessity for the patient based on either the diagnosis code or procedure code provided. It is recommended to attach a document and complete a guideline to support the authorization request, but you may move past this step with only one or the other (a completed MCG guideline or an attached document). The addition of both to the request may result in a faster automated determination.' Below this text is a section titled 'Clinical Criteria*' with a table. The table has four columns: 'Criteria ID', 'Criteria Title', 'Criteria Version', and an empty column. One row is visible with 'Invoke Criteria' in the first column and 'Remove' in the last column. At the bottom of the form, there is a 'Back' link on the left and 'Save' and 'Submit' buttons on the right.

Criteria ID	Criteria Title	Criteria Version	
Invoke Criteria			Remove

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:**

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

Review Guidelines

Please select 'Invoke Criteria' to launch into the MCG 'CareWebQI Auto-Auth' application. You will have the chance to document the medical necessity for the patient based on either the diagnosis code or procedure code provided. It is recommended to attach a document and complete a guideline to support the authorization request, but you may move past this step with only one or the other (a completed MCG guideline or an attached document). The addition of both to the request may result in a faster automated determination.

Clinical Criteria*

Criteria ID	Criteria Title	Criteria Version	
Invoke Criteria			Remove

Back Save Submit

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)

The screenshot displays the Predictal Auth Automation Hub interface. At the top, the header reads "predictal Auth Automation Hub". Below the header, there is a navigation bar with "MCG" and a "NEW" badge. The main content area is titled "Invoke Clinical Criteria" and includes a user profile for "Chad". A red box highlights the "Launch MCG" button. Below this, there is an "Exit" button. The "CLINICAL CRITERIA" section is visible, showing a table with columns for "Authorization request", "Provider", and "Member". The "Case Information" section includes "Authorization Type" (Medical-Outpatient) and "Case Type" (Prior Authorization). The "Request information" section shows "Start of Care Date" (09/10/2024). The "Member Information" section is also present.

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*).

Guideline Title	Product Code	Action
HMK Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	AC HMK Z-8-069	add
HMK Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	AC HMK Z-64-018	add
Surgical Treatment of Obstructive Sleep Apnea	AC S-280-002 HMK	add
Surgical Treatment of Obstructive Sleep Apnea	AC HMK S-280-001	add
No Guideline Applies		add

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.

Invoke CareWebQI® Guidelines

Click Submit after the transaction is complete

Clinical Indications

[Link to Policy: Z-64](#)

The healthcare resource is/was needed for appropriate care of the patient because of ...

- Diagnosis of OSA in pediatric individuals is made when ... criteria are met
- Diagnostic Testing via a facility/laboratory attended PSG may be medically necessary if ...
- PSG/RLS may be considered medically necessary for the diagnosis of periodic limb movement disorder when ... are criteria met
- Multiple Sleep Latency Testing (MSLT) may be considered medically necessary in pediatric individuals, after OSA has been ruled out by PSG, for ... medical conditions
- Actigraphy in conjunction with PSG may be considered medically necessary to evaluate sleep disorders when ... is present
- Positive Airway Pressure (PAP), CPAP in pediatric individuals may be considered medically necessary in ... situations

NOTE: PSG may be considered medically necessary when evaluating individuals with parasomnias when there is a history of sleep related injurious or potentially injurious disruptive behaviors.

NOTE: PSG in pediatric individuals not meeting the criteria as indicated in

Cancel **Submit**

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**.

predical™ Auth Automation Hub Exit AAH

Authorization Request

Actions

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

Review Guidelines
MCG*

ID	Name*	Status	
Invoke Criteria		New	Remove

Add

Back

Save Submit

Recent attachments (0) +

Show subcase attachments

5. Review Authorization

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

The screenshot shows the 'Review Authorization Details' page. At the top, there is a header 'Authorization Request' and a table with columns: Member Name, Member ID, Date of Birth, Client Name, Plan Type (Commercial), Case Type (Prior Authorization), Authorization Type (Medical-Outpatient), and Service Type (Medical Care). Below the header is a progress bar with five steps: 1. Member Search, 2. Authorization Details, 3. Enter Provider, 4. Review Authorization (current step), and 5. Confirmation. A warning message states: 'Review the information you've entered. You can use the Back button to make corrections. When you are ready, click the Submit button to finalize your request.' The main content area is divided into sections: 'Case Information' (Authorization Type: Medical-Outpatient, Case Type: Prior Authorization), 'Request information' (Start of Care Date: 12/04/2023), and 'Member Information' (First Name, Last Name, Member ID). A 'Tools' sidebar on the right contains 'History' and 'Recent attachments (0)'. A 'Back' button is located at the bottom left, and 'Save' and 'Submit' buttons are at the bottom right.

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.

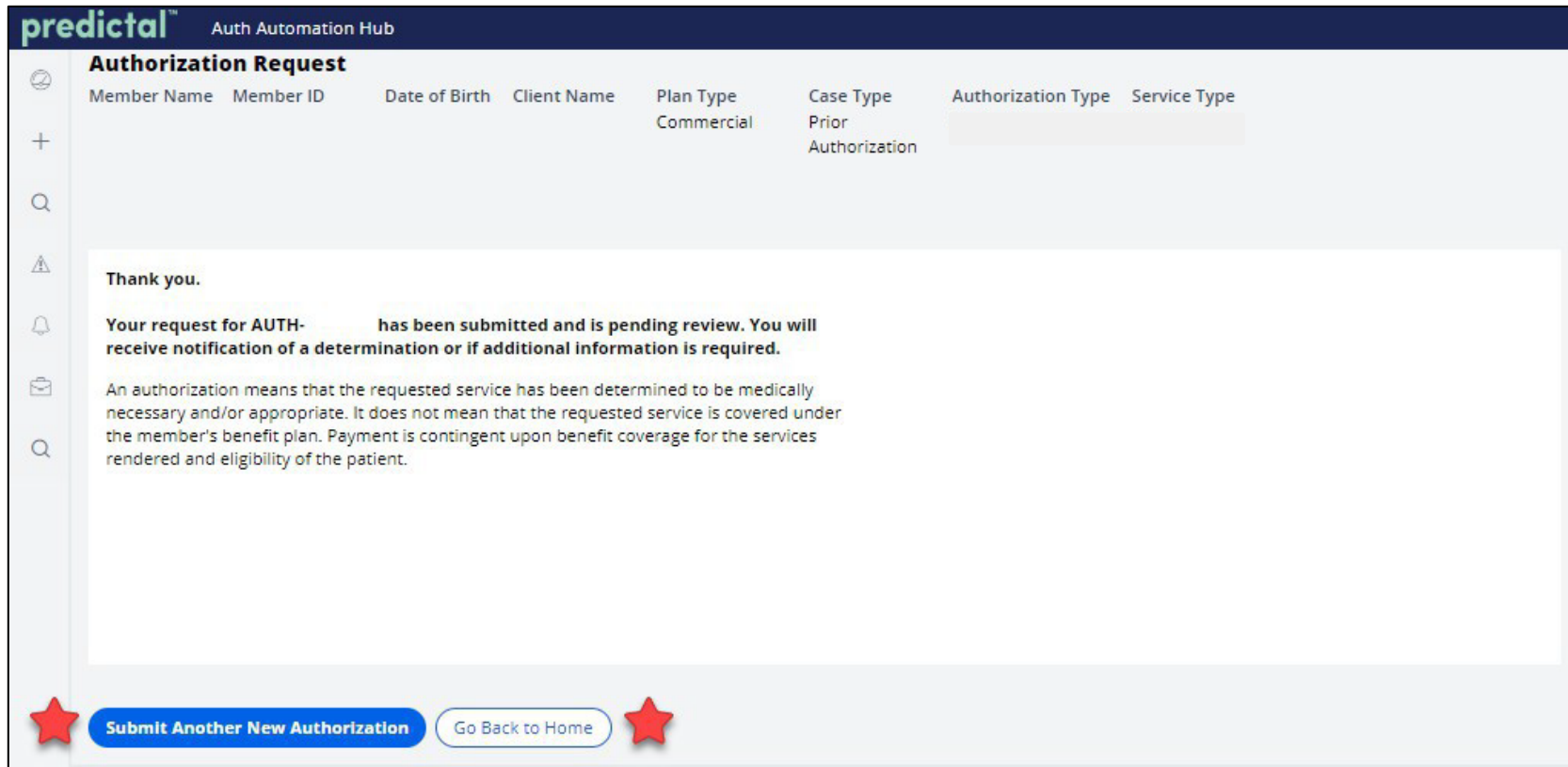
This screenshot shows the 'Review Authorization Details' page with more information. The header and progress bar are the same as in the previous screenshot. The 'Case Information' section is expanded to show 'Authorization Type: Medical-Outpatient' and 'Case Type: Prior Authorization'. The 'Request information' section shows 'Start of Care Date: 12/04/2023'. The 'Member Information' section shows 'First Name' and 'Last Name' fields. The 'Provider Details' section is expanded to show 'Ordering/Attending Provider' with a 'SUBMITTED BY THIS PROVIDER' badge, and 'Servicing Facility/Vendor'. Both sections have 'Provider ID' and 'Provider Name' fields. The 'Performing Provider' section is also visible. At the bottom, there is a 'Back' button on the left and 'Save' and 'Submit' buttons on the right.

6. Confirmation

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 screenshot displays the Predictal Auth Automation Hub interface. At the top, the Predictal logo and "Auth Automation Hub" are visible. Below this, the "Authorization Request" section shows a table with columns for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type, Authorization Type, and Service Type. The Plan Type is "Commercial" and the Case Type is "Prior Authorization".

A central message box contains the following text:

Thank you.

Your request for AUTH-_____ has been submitted and is pending review. You will receive notification of a determination or if additional information is required.

An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.

At the bottom of the screen, there are two buttons: "Submit Another New Authorization" (highlighted with a red star) and "Go Back to Home" (highlighted with a red star).

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

predictal Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Outpatient	Non-Urgent	Medical Care

Thank you.

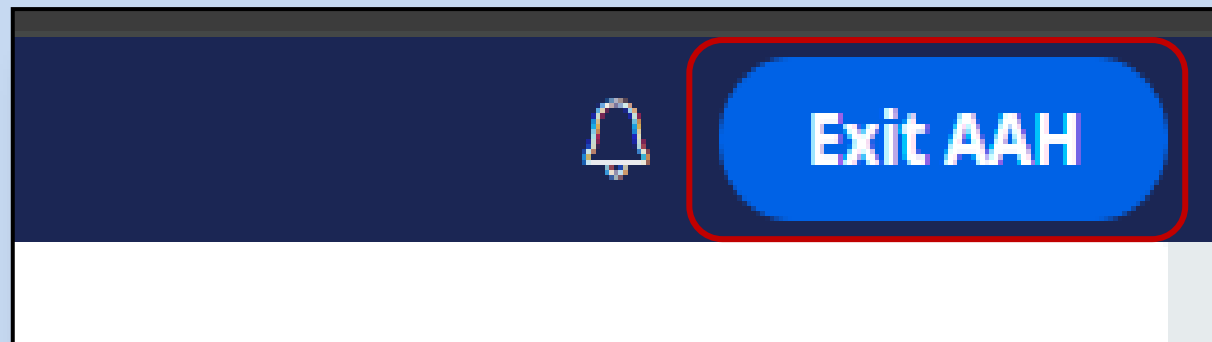
Your request for AUTH-88318 has been submitted. The following procedures are approved due to the reasons given below based on member's group information benefits and service type.

Procedure code	Description	Determination	Reason
01999	UNLISTED ANESTHESIA PROCEDURE(S)	Approved	Medical Necessity

An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.

Please logout by clicking your initials in the upper right-hand corner and then close the browser tab to return to NaviNet.

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**.

The screenshot shows the Predictal Auth Automation Hub interface. At the top, it says "predictal Auth Automation Hub" with a user profile icon. Below that is the "Authorization Request" section with a table of fields: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type (Medical-Outpatient), Urgency (Non-Urgent), and Service Type (Diagnostic Medical). A red box highlights a confirmation message: "Thank you. Your authorization number is AUTH-88313. Please select the submit button to launch eviCore Portal." Below the message is a blue "Submit" button. At the bottom, there are sections for "Review Authorization Details", "Case Information" (Authorization Type: Medical-Outpatient, Urgency: Non-Urgent), and "Request Information" (Start of Care Date). A "Recent attachments (0)" section is also visible on the right.

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.

The screenshot shows the Predictal Auth Automation Hub interface. At the top left is the Predictal logo and the text "Auth Automation Hub". A blue circle with a white "P" is in the top right corner. Below the header is the title "Authorization Request".

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Outpatient	Non-Urgent	Home Health Care

Thank you.

THIS REQUEST IS INCOMPLETE UNTIL YOU ENTER HELION CRITERIA

Your authorization number is AUTH-115243. **Please select the submit button to launch Helion Portal.**

Submit

Helion Arc Authorization Submissions

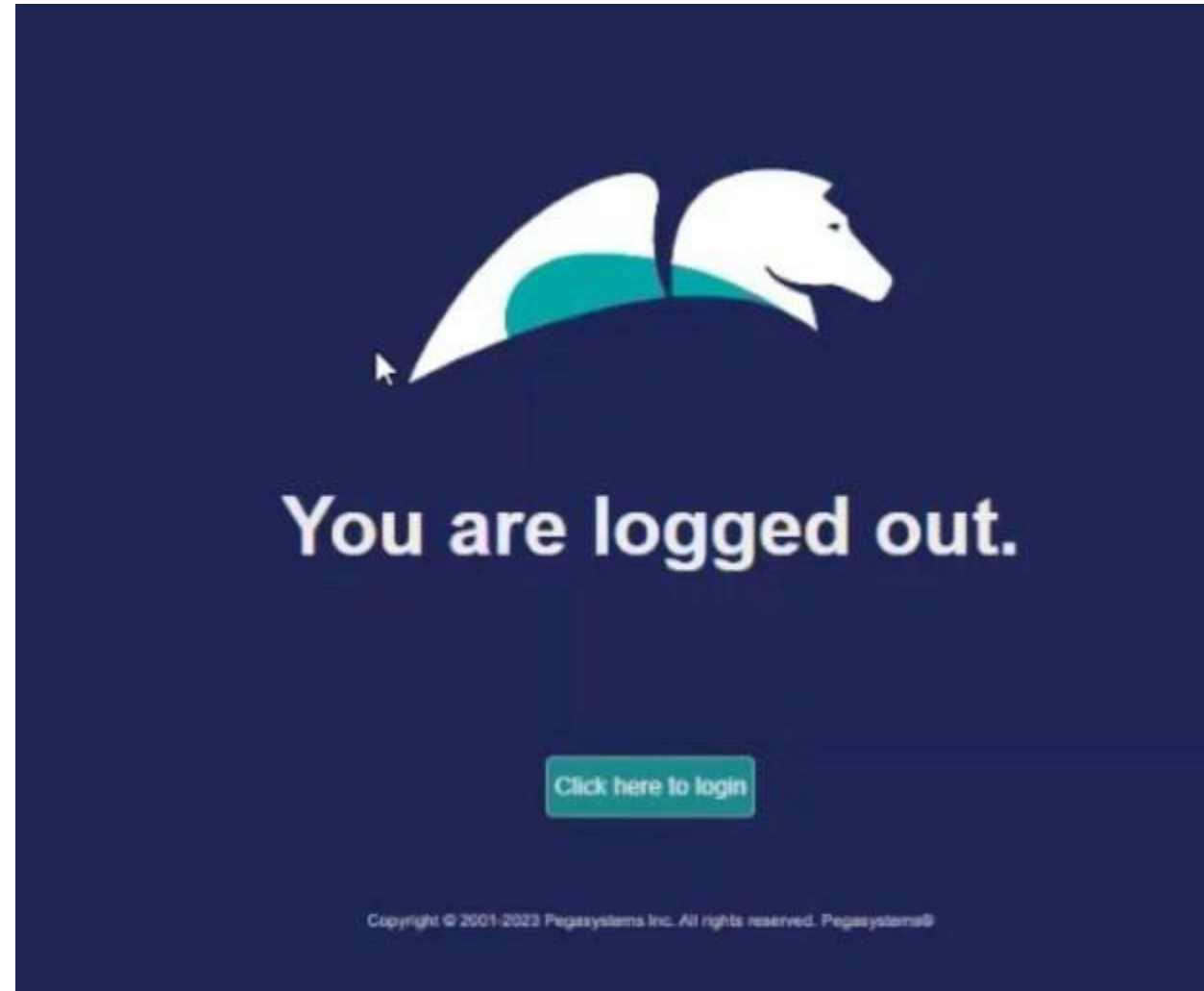
Users will get a notification that the request is incomplete until Helion criteria is entered.

Hit **Submit**.

The screenshot displays the Predictal Auth Automation Hub interface. At the top, the header includes the Predictal logo and 'Auth Automation Hub'. Below the header, there is a table for 'Authorization Request' with columns: Member Name, Member ID, Date of Birth, Client Name, Plan Type (Commercial), Case Type (Prior Authorization), Authorization Type (Medical-Outpatient), Urgency (Non-Urgent), and Service Type (Home Health Care). A message box contains the text: 'Thank you.', 'THIS REQUEST IS INCOMPLETE UNTIL YOU ENTER HELION CRITERIA', and 'Your authorization number is AUTH-111902. Please select the submit button to launch Helion Portal.' A blue 'Submit' button is highlighted with a red border. Below the message box is a 'Review Authorization Details' section with the following information:

- Case Information:** Authorization Type, Urgency (Non-Urgent)
- Request Information:** Start of Care Date (02/08/2023)
- Member Information:** First Name, Last Name, Member ID
- Group Information:** (collapsible)
- Detail Information:** Place of Service (Home), Service Type (Home Health Care)

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.*)

The screenshot displays the Helion Arc interface with a modal dialog box titled "Authorization Request Time Limit". The dialog box contains the following text:

90-minute time limit

Please be aware, you have 90 minutes to complete and submit this authorization request. If more time is needed you may cancel the request and start over when you have dedicated time.

Don't show again. **CONTINUE**

The background interface shows a progress bar with steps 1-5: Documents, Status, Requested Services, Review, Results. Below the progress bar is a table with the following data:

Patient Name	Date of Birth	Patient ID	Auth ID	Request Type	Method
Miller, Emma	09-Jan-1948	--	20231129150600	Initial	Fee for Service

Below the table is a "Documents" section with a "Drop PDF file here, or click to select." area. At the bottom of the interface, there are "CANCEL", "BACK", and "NEXT" buttons, and a "Time Limit" indicator showing "89 min 48 sec".

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

The screenshot displays a multi-step submission process. A progress bar at the top indicates five steps: 1. Documents (active), 2. Status, 3. Requested Services, 4. Review, and 5. Results. The main content area is titled 'Plan of Care' and includes a red 'Required' indicator. Below the title, it instructs the user to 'Please provide an updated plan of care' and specifies a 'Maximum file size: 10MB'. A table below shows a file upload area with the text 'no file chosen' and a 'REMOVE' button. At the bottom, a dashed box contains a cloud icon with an upward arrow and the text 'Drop PDF file here, or click to select.'

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.

Documents Status Requested Services **Review** Results

Patient Name Date of Birth Patient ID Auth ID Request Type Method
Start Of Care Fee for Service

Review

Note: After submitting to see Results you will NOT be able to make edits to this request.

Documents ✓ 3 of 3 Required Items Complete **EDIT**

Assessment ✓ ^

OASIS XML File
Filename
Valid OASIS-E SOC.xml

Supplementary Assessment Items ✓ ^

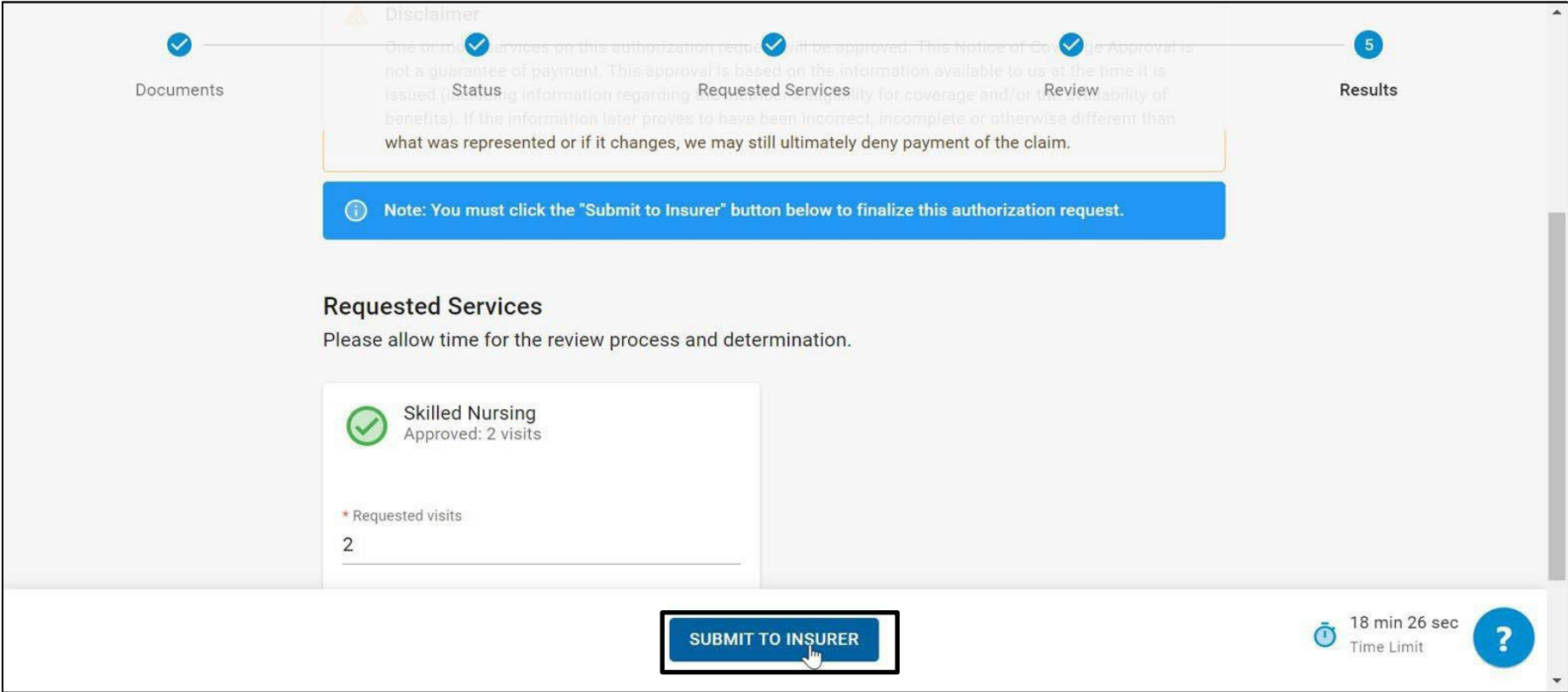
CANCEL ← BACK **SUBMIT**

22 min 33 sec
Time Limit ?

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.

The screenshot displays the Helion Arc dashboard interface. The top navigation bar includes the Helion Arc logo, a search bar, and the text 'DEFAULT TEST TENANT'. The left sidebar contains navigation links for Dashboard, Conversations, Authorization Requests, Patients, and Surveys. The main content area is titled 'Dashboard' and features a section for 'Active Authorization Requests' with a filter set to 'ALL STATUSES' and a sort order of 'SUBMIT DATE: NEWEST'. A specific request for 'HOME HEALTH' is highlighted, showing a submit date of '10-Feb-2023' and a status of '1 service approved'. A callout box with a black border highlights a green checkmark icon with an upward arrow, and two buttons labeled 'VIEW PATIENT' and 'VIEW REQUEST' at the bottom of the callout.

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.

Dashboard > Authorization Requests > Auth ID: AUTH-1

Auth ID: AUTH-1

Care Setting	Request Type	Product	Servicing Provider	Reimbursement Method
Home Health	Start Of Care			Fee for Service

Authorization Request Details
View requested service(s), reason(s) for care, and additional details for this authorization request.

REQUESTED SERVICES 1 | **STATUS** | **DOCUMENTS**

Skilled Nursing START CONVERSATION

✓ This requested service has been approved. See additional information below.

Visits Approved	Visits Requested	Last Covered Date	Proposed Date of Service
3	3	05-Apr-2023	08-Feb-2023

Reasons For Care

Ongoing Assessment Needs

Patient Details

Patient Name: [REDACTED]
Date of Birth: [REDACTED]
Patient ID: [REDACTED]

Submission Details

Submission Date: 10-Feb-2023
Submission Time: 14:39
Submitter: [REDACTED]

Authorization Request Activity ?

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

The screenshot displays the Helion Arc interface for an authorization request. The top navigation bar includes a search function, the tenant name 'DEFAULT TEST TENANT', and a 'TASKS' button. The left sidebar contains navigation options: Dashboard, Conversations, Authorization Requests, Patients, and Surveys. The main content area is titled 'View requested service(s), reason(s) for care, and additional details for this authorization request.' It features three tabs: 'REQUESTED SERVICES' (with a notification badge), 'STATUS', and 'DOCUMENTS'. Under the 'DOCUMENTS' tab, a table lists the following items:

Type	Name	Date Added
OASIS Assessment	Valid OASIS-E SOC.xml	10-Feb-2023
Plan of Care	testfax.pdf	10-Feb-2023

Below the table, a 'Processing Files' section indicates that 'testfax.pdf' is being processed. At the bottom of the main area, there is a 'SUPPORTING DOCUMENTS' section with a table that currently shows 'No documents uploaded' and a dashed box for uploading files with the instruction 'Drop PDF, DOC, or DOCX file here, or click to select.' The right-hand side of the interface contains three summary panels: 'Patient Details' (showing Patient Name, Date of Birth, and Patient ID), 'Submission Details' (showing Submission Date as 10-Feb-2023, Submission Time as 14:39, and Submitter), and 'Authorization Request Activity' (showing a status of 'Approved by Insurer' for 'Skilled Nursing' and a note 'Request Submitted by Provider').

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.

The screenshot shows the Helion Arc web application interface. The browser tabs at the top are highlighted with a red box, showing 'Auth Automation Hub', 'You are logged out.', and 'Auth ID: AUTH-111902'. The page displays details for an authorization request, including care setting (Home Health), request type (Start Of Care), product, servicing provider, and reimbursement method (Fee for Service). It also shows a table of requested services and documents, a patient details section, and submission details.

Care Setting	Request Type	Product	Servicing Provider	Reimbursement Method
Home Health	Start Of Care			Fee for Service

Authorization Request Details

View requested service(s), reason(s) for care, and additional details for this authorization request.

REQUESTED SERVICES 1 STATUS DOCUMENTS

Type	Name	Date Added
OASIS Assessment	Valid OASIS-E SOC.xml	10-Feb-2023
Plan of Care	testfax.pdf	10-Feb-2023

Processing Files
The following files are processing:
• testfax.pdf

Patient Details

Patient Name
Date of Birth
Patient ID

Submission Details

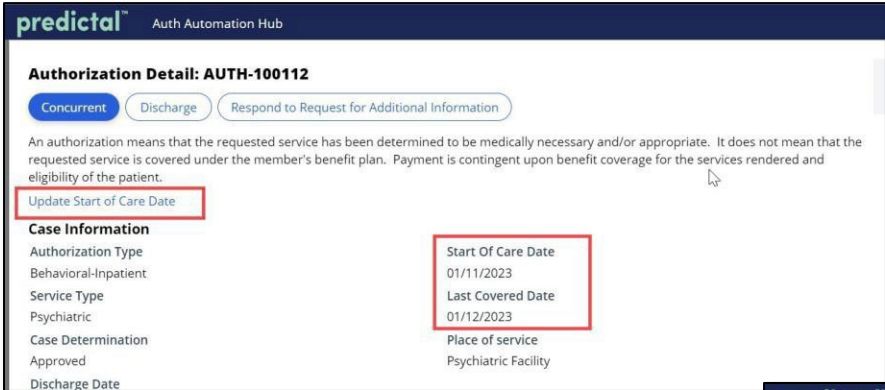
Submission Date: 10-Feb-2023
Submission Time: 14:39
Submitter

Availity Provider Portal Predictal Authorization Inquiry

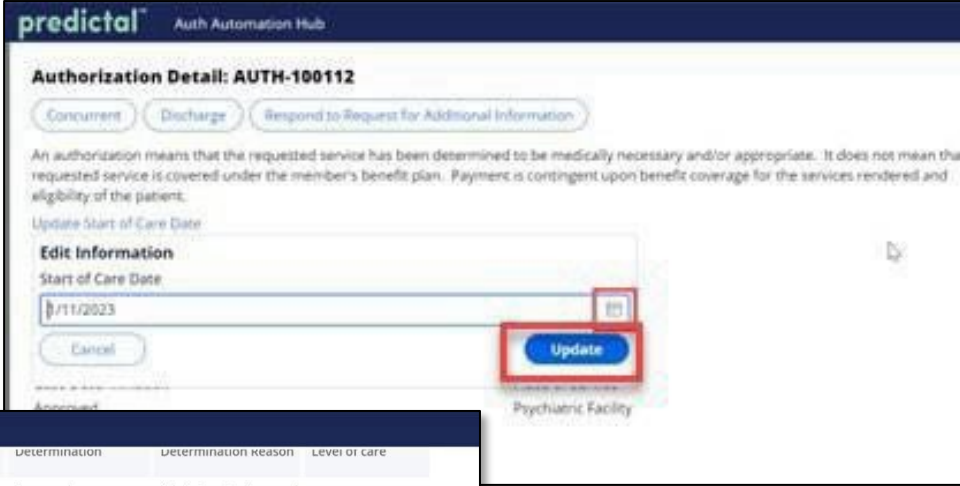
To update the **Start of Care Date** after the authorization is submitted:

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. Select the **Save Changes** button.

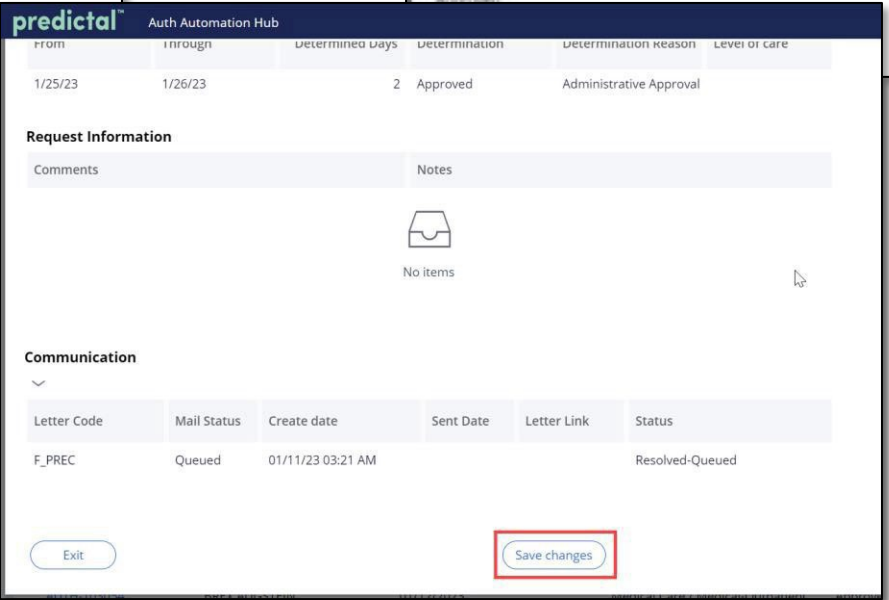
Step 1



Step 2



Step 3



The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

This presentation is accurate as of the date it is presented but may change pursuant to regulatory requirements for this program or in response to changing business needs. The contents of this presentation are the property of Highmark Inc., Highmark Health, and/or its subsidiaries (“Highmark”). The information contained in this presentation is confidential and proprietary and is not to be distributed to any outside person(s) or entit(ies) without the express written consent of Highmark.