Physical Medicine Management Program Changes – FAQs

For providers in New York

May 2024

Physical Medicine Program Changes

- Physical therapy (PT) may begin submitting April 26, 2024, for an effective date May 1, 2024, or later.
- Occupational therapy (OT) may begin submitting April 26, 2024, for an effective date May 1, 2024, or later.

Provider Resource Centers

Highmark Western NY Provider Resource Center (highmarkprc.com)

- Availity – Provider Portal Transition
- Availity – Provider Portal Transition FAQs
- List of Procedures/DME Requiring Authorization

Highmark Northeastern NY Provider Resource Center (highmarkprc.com)

- Availity – Provider Portal Transition
- Availity – Provider Portal Transition FAQs
- List of Procedures/DME Requiring Authorization

Utilization Management (UM)

Q1: What line of business does this prior authorization requirement impact?
A1: The prior authorization change for PT and OT applies to members in Commercial plans.

Q2: Where do I go to submit an authorization request?
A2: The Electronic Authorization (eAuth) process starts in Availity®. Select **Payer Spaces**, applicable Highmark logo, and Predictal application tile. For information on Availity, please visit your region's Provider Resource Center.

Q3: What is the difference between an Initial Request versus Extension Request?
A3: The Electronic Authorization (eAuth) process starts in Availity and leads to the Helion Arc Technology Platform. Instructions to submit an initial authorization via Availity:

- Choose your state.
- Click **Payer Spaces** in the navigation bar.
- Select the Highmark logo.
- Under **Applications** in Highmark Payer Spaces, click **Predictal**™.
- In Predictal, select **New Authorization**.

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

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

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

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

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

A4: A separate authorization is required for each profession delivering care. For example, a Physical Therapist will need a separate authorization than an Occupational Therapist or Speech Therapist.

Q5: What do we choose under Service Type after we have selected our "Place of Service"?

A5: For all outpatient clinics/offices, you must choose "**Rehabilitation**" as your Service type to be able to complete the Procedure Information that should consist of dropdowns for PT, OT, and Speech Therapy (ST) with the procedure codes that are associated with that discipline.

Q6: What is the timeframe to submit the initial request?

A6: The evaluation does not require a prior authorization. You will need to submit for authorization within 21 days of the start of care date.

Q7: How do providers submit retrospective review requests?

A7: For retrospective review requests, providers are encouraged to utilize the Provider Portal. If the request falls outside of the Provider Portal acceptance threshold, providers can contact Provider Service at 800-950-0051.

Q8: How do I file an appeal?

A8: Information on how to file an appeal as noted below will be reflected in the Initial Adverse Determination (IAD) letter. Requests for appeals may be submitted either by telephone or in writing. A provider has 180 days from the date of the initial denial of coverage.

There are two types of appeals available to the provider following a medical necessity denial – expedited appeal or standard appeal. The type of appeal is determined by the urgency of the situation and the physician's assessment of it.

To initiate a provider appeal by phone, contact Clinical Services by calling: 844-946-6263.To initiate by mail, submit all pertinent information to the address below for Commercial appeals:

Utilization Management Appeals Unit
P.O. Box 4208
Buffalo, NY 14240

Q9: Will providers still be able to request Peer-to-Peer evaluations?

A9: To initiate a Peer-to-Peer request providers should call the dedicated, peer-to-peer phone number: 866-634-6468. Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday.

Q10: How will providers initiate date changes, extensions, or obtain answers to other Utilization Management questions?

A10: Contact the Highmark Utilization Management Team by calling 844-946-6263 or faxing 833-619-5745.

Q11: If I am currently treating a patient prior to the authorization effective date of May 1, when do I have to submit a prior authorization?
A11: Any therapy services after May 1 will require a prior authorization.

Q12: Will providers still be able to phone or fax requests?
A12: Yes, however, you will be able to receive authorization determinations faster with electronic submissions. We highly encourage you to use the portal when submitting authorization requests.

Q13: How do I submit a claims inquiry?
A13: You will need to initially submit an Availity investigation for claim inquiries. For escalation or questions, contact Provider Service at 800-950-0051.

Helion Arc Technology Platform

Q1: What is Helion Arc?
A1: Helion Arc is integrated with the PredictalTM Utilization Management (UM) tool and enables offices to submit, update, and query medical authorization requests.

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

Q2: Do I need to request access to Helion Arc to submit an authorization request?
A2: At this time, electronic authorization submissions can be processed within the Helion Arc Technology Platform through a seamless transition that does not require direct access or login.

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

Q3: How many visits would be eligible for approval?
A3: Visit amounts will vary based on provider performance, responses submitted within Helion Arc each calendar year.

Q4: Does Helion Arc require Plan of Care?
A4: Helion Arc does not require the Plan of Care for initial authorization requests but does require a Plan of Care for extension requests.

Q5: Can you submit multiple diagnosis codes?
A5: You need to submit the diagnosis code(s) that are pertinent to your Plan of Care for the patient.

Q6: Why do we only have 90 minutes to complete the information within Helion Arc and what happens if we do not complete within that timeframe?
A6: The 90-minute timeframe is set up that way to mitigate potential exposure of member information on the screen for too long. If you do not complete within the 90-minute timeframe, your information will be lost, and you will need to start over.