Authorization Guide

- **All referrals must be sent to Clinical Specialties prior to start of care. You can verify if we have a referral on file by viewing the active case under your CSI Portal account. Please refer to the Provider Portal Guide for step-by-step instructions on submitting a new referral and requesting authorizations via the CSI Portal.**

- **CSI will provide benefits and eligibility information and secure the authorization with the payer on your behalf. Please note - *Authorization is NOT a guarantee of payment. Reimbursement is subject to medical necessity and patient's eligibility with the Payer at the time the service is rendered.***

  - To check the status of a pending home health authorization request, call 440.717.1700 option 1, option 2
  - Always review Black Box section of authorization/notification form for specific plan requirements
  - If applicable Clinical Specialties will provide any payer specific insurance forms needing completed if required
  - It is the responsibility of the agency to request the initial and ongoing authorizations from CSI and track the number of visits authorized in a timely manner
  - Please remember to review the patient's medical insurance at each visit and notify CSI immediately of any changes or discrepancies, as patient's insurance may change
  - For any payers not requiring prior authorizations for service, it is the home health provider's responsibility to ensure that the services provided are medically necessary and ensure Medicare Guidelines are followed for all Medicare Advantage Plans.
  - If a patient is hospitalized during authorization period, notification is required as a new auth may be required upon resumption of services

Documentation needed for requesting Authorizations

For payers requiring *Initial* Authorization for services:

- Home Health Care orders
- Discharge summary- if patient is coming from a facility
- Updated clinical documentation/history and physical
- ST, MSW, and HHA are not considered for initial authorizations; please request these services with ongoing authorization after initial home health evaluation is complete
- Payer's initial authorizations may be for limited visits or eval visit only, to allow your agency to collect clinical information
- **All** claims for HHA must include the SN or PT on the same claim, this is a requirement of some payers to ensure oversight of HHA visits

For payers requiring *Ongoing* Authorization for services:

- Date to start the ongoing auth request include each discipline with the number of additional visits needed for that certification period
- Current signed 485 and any subsequent orders
- Oasis/Evaluations
- Recent visit notes
  - For PDN include last 7-14 days of visit notes, For all other services include last 3-5 days of visit notes
- CSI will notify your agency if a payer has any additional requirements
- **All** claims for HHA must include the SN or PT on the same claim, this is a requirement of some payers to ensure oversight of HHA visits

Payer Specific Authorization Requirements

Information listed below is to serve as a general guideline regarding payer specific authorization requirements Individual plans may vary; Clinical Specialties will notify your agency if additional payer specific information is required.

AETNA

Medicare Advantage (MA) Plans and Commercial Plans

- Initial and ongoing authorizations are not required for SN, PT, OT, ST, MSW, or HHA
- Private Duty Nursing (PDN) IV Nursing (99601/99602) and Hospice Services require both initial and ongoing authorization

Third Party Aetna Plans (i.e. Meritain)

- Initial and ongoing authorizations are required for all Home Health and Hospice Services

***For all Aetna Plans**

- Skilled Nursing must differentiate between RN (G0299) and LPN (G0300)
- Home Health Aide visits must be billed on the same claims as the primary discipline (SN/PT)

BE PREPARED TO PROVIDE THE CLINICAL DOCUMENTATION FOR INITIAL AND ONGOING AUTHORIZATION REQUESTS. CSI WILL NOTIFY OF ANY ADDITIONAL REQUIREMENTS UPON BENEFIT AND ELIGIBILITY VERIFICATION.

REMEMBER to ALWAYS discharge a patient's case when services are complete to avoid delays in the event future services are needed