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AUTHORIZATION GUIDE-OHIO

Reference the Provider Portal Guide for step-by-step instructions on submitting a new referral and requesting authorizations via the CSI AlayaCare Portal. When the portal is not available you can Fax the authorization request to 440.550.8835

The Information listed in this guide is to serve as a general guideline about payer specific authorization requirements, individual plans may vary; CSI will notify your agency if added payer specific information is needed

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*

HELPFUL INFO:

- All referrals managed by CSI (**non- Carelon**) must be entered onto the CSI AlayaCare portal for benefit verification and authorization (when needed) prior to the SOC.
- To check the status of a pending authorization (**non-Carelon**) use the mail message form on the portal or call 440.717.1700 option 2 for CSI, option 1 for Referral/Authorization
- Review your Provider Authorization Form for specific plan information which is faxed or emailed to your agency
- Be sure Patient information on the claim matches the CSI authorization form to avoid claims rejecting for discrepancies, such as spelling of name, DOB, etc.
- It is the responsibility of the agency to request the initial and ongoing authorizations and track the number of visits used against the authorization
- When possible, please provide CSI with a copy of the patient's medical insurance ID Card
- Review the patient's medical insurance at each visit and notify CSI immediately of any changes or discrepancies using the mail message form on the AlayaCare portal indicating in the comment box what is needed, new policy update information can be added as well
- After the initial benefit check CSI will only recheck benefits at your request
- Any payer not requiring prior authorizations for service, ensure that Medicare Guidelines for medical necessity are being followed for Medicare Advantage Plans
- When a patient is hospitalized during an authorization period, notification to CSI is needed as some payers may require a new auth upon resumption of care
- If applicable CSI will supply any payer specific insurance forms needing completed
- To reduce processing delays with payers, provide the documents needed located below unless indicated differently in that payer specific section
- **All claims for HHA must include the SN or PT on the same claim, this is a requirement of payers to ensure oversight of HHA visits**

Documentation needed for initial, ongoing authorization and Resumption of Care unless otherwise indicated in the Payer Specific Authorization Requirements

Initial Authorization:

- 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 completed
- Payer's initial authorizations may be for limited visits or eval visit only, this allows your agency to collect clinical information to present additional authorization requests

Ongoing Authorizations and Recertifications:

- **Date to start the ongoing auth request includes each discipline with the number of additional visits needed for that certification period**
- Current signed Plan of Care (485) and any subsequent order
- SOC Oasis
- Recert OASIS
- Discipline specific Evaluations
- Recent (2-3) visit notes for each discipline
    - For PDN include the 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 player has any additional requirements

If all documents are not received on your initial or ongoing AUTH request, CSI will FAX to your agency an additional clinicals request, listing specific documents that are needed. Please understand this also could delay the payers processing time and some payers will restart the clinical review once all documents are received.

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PAYER SPECIFIC REQUIREMENTS

ANTHEM

CSI is not able to bill for IV nursing 99601-99602 for Anthem for any plans

ANTHEM COMMERICAL and MEDICARE ADVANTAGE PLAN (non- Carelon)

- Requires initial and ongoing authorization for all Home Health and Hospice Services
- Ohio Commercial plans will only back date 2 days, usually these plans have 3-letter prefix followed by numbers with 1 letter in the middle. example ESN1234M1234 Auth approval is usually 3-5 days
- Ohio Medicare Advantage plan with prefix **AJY** whose authorization is managed by the Utilization Management Dept at Anthem, does not backdate for initial or ongoing requests. This plan also has 3-letter prefix followed by numbers with 1 letter in the middle.
- Out of States plans vary and backdates can be 0-5 days. Auth approvals for these plans can take 7-14 days to complete approval
- If applicable, please follow the instruction below regarding Eval visit only on initial request

BLUE CROSS/BLUE SHIELD PLANS

- Initial and ongoing authorizations are required for all services
- Ohio and Out of State vary on backdates per plan
- These plans can take up to 14 days to review documentation and approve authorizations
- If ALL clinicals are not available for CSI to upload to the payer, when additional clinicals must be requested, the 14 days can start over again when the additional clinicals are uploaded to the payer
- If applicable, please follow the instruction below regarding Eval visit only on initial request

HIGHMARK BC/BS

- HRT prefix is a Highmark Medicare Advantage plan that only allows eval visits upfront for the Initial authorization request.
    - Once eval is completed, a request for ongoing auth needs to be submitted to CSI, follow the portal ongoing auth request, upload the EVAL notes with the additional documents listed from our document section.
- Highmark Commercial varies per plan if auth is needed or eval upfront.
    - Your initial Provider Auth Form will indicate EVAL only or 1 visit approved per discipline
    - If applicable, please follow the instruction below regarding Eval visit only on initial request

***Ongoing authorization for both Medicare Advantage and Commercial plans for this payer will need the start date for ongoing request with the document.**

Some policies will only authorize an evaluation visit on your initial request. Review your Provider Authorization form to confirm if it indicates "eval only" or a "single evaluation" for one service when multiple services were requested. If this is noted on the Provider form once the evaluation visit has been completed your agency will need to complete an Additional *Authorization Request form* on the portal listing all services and visit needed with the Start date outside of the 1 approved eval visit along with the evaluation notes and any documentation outlined on the Provider Form

AETNA

AETNA COMMERICAL 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 PARY 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)

Some payers ongoing auth request is based on date range i.e., Anthem, Third Party Aetna, Frontpath, OSU and OH PPO Connect- CSI's auth team will advise your agency if it is NOT by certification period for future requests

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MEDICAL MUTUAL OF OHIO (MMO)

MMO MA and COMMERICAL PLANS

- Initial and ongoing authorizations are not required for SN, PT, OT, ST, MSW, and HHA
- Initial and ongoing authorizations are required for PDN and Hospice Services
- **Some Third-Party Administrators for MMO Commercial plans may require precertification for services**

THE HEALTH PLAN/Hometown

MEDICARE ADVANTAGE (MA) PLANS

- Initial and ongoing authorizations are required for all services

COMMERICAL PLANS

- Initial and ongoing authorizations are required for all service

For all Plans (both MA and Commercial)

- Insurance specific re-authorization forms need to be completed specific to each discipline, CSI will provide these forms with authorization requests
- The Health Plan will not provide retro authorization. If services are rendered after hours, over the weekend or on a holiday, providers are required to request authorization on the next business day. Prior authorization requests received after the next business day will not be backdated
- Please include a current 485 with the referral as well as with all ongoing authorization requests, as this payer requires for billing

UNITED HEALTH CARE (UHC)

CSI cannot bill for IV nursing 99601-99602 for UHC for any plans
Skilled Nursing must differentiate between RN (G0299) and LPN (G0300) for all UHC plans
Hospice- Routine and Respite Disciplines only

UHC MEDICARE ADVANTAGE PLANS

- *Most* UHC MA plans do not require Initial and ongoing authorizations

UHC COMMERICAL PLANS

- Initial and ongoing authorizations are required for all service

UHC managed by UMR

- 48-Hour Advance Notice for all authorization requests
- Signed physician orders and clinical are required with your request for a Start of Care
- UMR requires at least 48-hour notice before initiating care. If this notice is not provided, services for dates prior to the 48-hour notice may be denied, even if the service is authorized.

***Not providing the signed Home Care Physician orders and Discharge Summary/H&P will cause UMR to void our initial request.**

- For ongoing authorization requests provide at least 48-hour advance notice, be sure to include the signed 485, OASIS and visit notes with the request
- UMR will not backdate initial or ongoing request for authorization
- Authorization is required for all Home Health Care Services
- Authorization request can take 4-14 days for both initial and ongoing

Some policies will only authorize an evaluation visit on your initial request. Review your Provider Authorization form to confirm if it indicates "eval only" or a "single evaluation" for one service when multiple services were requested. If this is noted on the Provider form once the evaluation visit has been completed your agency will need to complete an Additional *Authorization Request form* on the portal listing all services and visit needed with the Start date outside of the 1 approved eval visit along with the evaluation notes and any documentation outlined on the Provider Form

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CARELON

Plans managed by Carelon are:
Aetna Medicare Advantage Plans (most) in Ohio
Anthem Medicare Advantage Plans in Ohio for the following prefixes: JRI, JRG, VOC, VOD, ZVR, AFH

- Go directly to Carelon to submit your referral and request authorizations, you do not need to submit the patient referral to CSI for any plans Carelon manages authorizations for
  - access the Carelon portal to request authorizations at: **https://portalct.mynexuscare.com/**

- Be sure to select "**CSI**" as the Provider Network on the Carelon portal
  - On tab 4 – ***service provider***, choose **CSI** from the Provider Network drop down menu. If your agency is only contracted with CSI for Carelon, the Provider Network should default to CSI Network
  - In the event you need to fax an authorization request to Carelon, be sure to indicate that the Provider Network is **CSI**

- For any authorizations associated with CSI as the Provider Network on the Carelon portal, CSI will capture the patient referral information directly from Carelon and load this data into our system. Once benefits/ eligibility is verified we will fax/email the benefits to the agency.
  - CSI will not have access to any patient referral information if the authorization is not under the CSI Network (tab 4) Provider Network on the Carelon Portal

- Do not wait on CSI for benefit verification to start your authorization process with Carelon
  - The time limit for accepting a backdated authorization request under CSI is five (5) business days
  - If Carelon does not show a patient in their portal you are attempting to request authorization on, submit the referral to CSI to verify if the plan goes through Carelon

- Carelon will communicate directly with your agency on any clinical questions and provide you with your initial and ongoing authorizations

- Per CMS guidelines Carelon will make ***two*** outreach attempts for additional information required for clinical review. Please ensure the required documentation is submitted to Carelon for proper review

- For any out-of-scope plans not managed by Carelon, submit the patient's referral directly to CSI for benefit verification to confirm if we can accept the plan

- Carelon has a standardized 30-day review period for all home health authorizations
  - When requesting authorization, be sure to request the number of visits needed for a full 30-day review period as Carelon will auto approve, where appropriate the number of visits for a 30-day window
  - Approved visits within a review period cannot be moved to another 30-day review period

FOR ALL PLANS NOT LISTED ON THIS GUIDE, PLEASE FOLLOW THE DOCUMENTATION FOR INITIAL AND ONGOING AUTHORIZATION REQUESTS SECTION ABOVE. CSI WILL NOTIFY YOUR AGENCY OF ANY ADDITIONAL REQUIREMENTS UPON BENEFIT AND ELIGIBILITY VERIFICATION

Remember to Discharge a patient's case when services are completed to avoid delays if future services are needed