Authorization Guide

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.
- For payers managed by Carelon go to the Carelon portal to start your authorization, CSI will capture the patients' data from a daily roster, YOU MUST choose CSI as the Provider Network (tab4) to show on our roster
- To check the status of a pending authorization (**non-Carelon**) use the mail message form on the portal or call 440.717.1700 option 1, option 2
- Review your Provider Authorization Form for specific plan information which is faxed or emailed to your agency
- 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 periodically 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

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 payer has any additional requirements

***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**

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

When 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

Payer Specific Authorization Requirements

Unless otherwise indicated follow the Documentation needed when Authorization is required for initial and ongoing listed above

ANTHEM

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

Anthem Commercial 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

BLUE CROSS/BLUE SHIELD PLANS

- Initial and ongoing authorizations are required for all services
- Ohio and Out of State varies 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

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.
    - For plans that approve eval visits upfront only, 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.
    - Your initial Provider Auth Form will indicate EVAL only or 1 visit approved per discipline

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

AETNA

Aetna 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)

MEDICAL MUTUAL OF OHIO (MMO)

MMO MA Plans and Commercial 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

Commercial 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 is not able to 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

UHC managed by UMR

- Initial and ongoing authorizations are required for all services
- Authorization request can take 4-14 days for both initial and ongoing

*Please note: UMR may require 48 hours advance notice for start of care. If that criteria are not met,

UMR may impose a financial penalty on the patient. Both the initial and ongoing authorization requests must be requested two business days in advance

UHC- MDCR Advantage Plans that are managed by HOME & COMMUNITY CARE (formally NaviHealth)

- On April 1, 2025, Home And Community Care will no longer be managing the authorization of any United Health Care Medicare Advantage Plans

- Although prior authorizations may no longer be required for dates of service starting April 1, 2025, you are expected to provide home health services according to Centers for Medicare & Medicaid Services coverage guidelines

- On all existing cases, we suggested checking with your patient to verify their plan hasn't changed

- When needed a request can be sent to CSI to do a benefit re-verification on the CSI AlayaCare portal using the mail message form

UNITED HEALTH CARE (UHC)

UHC managed by OPTUM

Prior authorization is required for all home health services after the initial start of care (SOC) and subsequent visits between days 1-14. **Optum will NOT backdate** after day fourteen (14) of the first certification period, if auth is not obtained before services are rendered, claims may be denied.

Start of Care

- Within 24-48 hours of the Start of Care, submit your referral to CSI to verify benefits/eligibility include the start date and disciplines needed for days 1-14.
- **CSI is required to provide Optum with the patient's Start of Care (SOC) within 72 hours with disciplines only**
- If SOC date needs corrected/changed notify CSI within 72 hours

Prior Authorization

- Around day seven (7) of the first 14 days of the initial SOC submit the documentation below to CSI with your authorization request for disciplines and visits needed for days 15-60**. You do not need to include visits used for days 1-14.**
    - 485/Plan of Care- this will be reviewed to confirm visits are correctly accounted for and will be reviewed for medical necessity
    - Start of Care OASIS
    - Discipline specific Evaluations
    - Documentation to support homebound status/ need for intermittent care
    - Any Physician orders not included on the 485
    - Wound Care Notes (if applicable)
    - The last two (2) recent visit notes for each discipline involved

Resumption of Care (ROC)

- When the patient comes back on service, any auth that was *not used* prior to their hospitalization is still valid within that certification period, if any additional visits or disciplines are needed, CSI will need to be notified to request authorization and include supporting clinical documentation.

Recertification

- **All recertifications require prior authorization in 60-day increment**
- Between days 40 to 50 provide disciplines and number of visits needed for the new cert period to CSI
- The last two (2) recent visit notes along with any relevant clinical documents

Additional discipline visit / add new discipline for certification period

If there is any modification to a member's care plan on CSI's portal submit your request prior to the service date.

- For add-on disciplines provide the number of visits needed for that certification period with the start date along with physician orders and clinical's applicable to this request.
- If additional visits are needed on a previously approved discipline within a certification period, provide the number of visits needed with the **date to start those visits** with the end date of the certification period along with physician orders and clinicals applicable for this request. All additional visit requests must be submitted and approved prior to the requested start date.

NOMNC

- If CSI received a NOMNC request for a patient, we would forward this request to your agency and ask that you reply directly to Optum following the directions on the letter.

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

- **Effective May 16, 2025, Carelon Medical Benefits Management will be introducing a standardized 30-day review period for all home health authorizations**
    - **When requesting initial authorizations in the portal, your authorization request will automatically be assigned to a 30-day date range, instead of a 60-day date range as it does today**
    - **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