

CASENET AUTHORIZATION MODULE

Suggestions on How to fill in the Place of Service Field and the Requested Service Field

Covered Service	Place of Service	Service Category	Requested Service	Prior Auth required	Notes
Ambulatory/Day Surgery	Outpatient Hospital or Ambulatory Surgical Center	Ambulatory/day surgery	Ambulatory setting substance	Yes	Add specific surgery type in the Notes section (e.g. cataract surgery, soft tissue biopsy)
Behavioral Health Services					
<i>Home Mental Health</i>	Home	Behavioral Health services	Mental health service, nos	Yes	
<i>Inpatient Mental Health</i>	Inpatient Psychiatric Facility or Inpatient Hospital	Behavioral Health services	Psych hlth fac svc, per diem	Yes – entered by CCA Clinical staff.	
<i>Outpatient Mental Health</i>	Office or Outpatient Hospital	Behavioral Health services	Mental Health services, nos	Yes	Referral required after 12 visits
<i>Partial Hospitalization</i>	Psychiatric Facility- Partial Hospitalization	Behavioral Health services	MH partial hosp tx under 24h	Yes	
Community-Based Services					
<i>Adult Day Health</i>	Other Place of service	Adult Day Health	Adult day care per diem	Yes	
<i>Adult Foster Care/Adult Group Care</i>	Home or Assisted Living Facility	Adult Foster Care	Adult Foster Care, per month	Yes	

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Community-Based Services (continued)					
<i>Chore</i>	Home	Community Based Service	Chore services, per diem	Yes	
<i>Companion</i>	Home or Other Place of Service	Community Based Service	Adult Companion care, per diem	Yes	
<i>Dementia day care</i>	Other Place of Service	Adult Day Health	Adult day care, per diem	Yes	Add dementia day care in notes
<i>Environmental accessibility adaptations</i>	Home	Community Based Services	Home environment assessment	Yes	Add specifics in notes
<i>Homemaker</i>	Home	Community Based Services	Home maker service nos per 15m	Yes	
<i>Interpreter Services</i>	Home or Other Place of Service	Community Based Services	Sign Lang/Oral Interpreter	Yes	
<i>Laundry</i>	Home	Community Based Service	Laundry serv,ext,prof,/order	Yes	
<i>Meals on Wheels</i>	Home	Community Based Service	Home delivered prepared meal	Yes	
<i>Personal Care Attendant (PCA) Services</i>	Home	Personal Care Attendant Services	Personal care ser per diem	Yes	
<i>Personal Care Homemaker</i>	Home	Community Based Services	Homemaker Services, nos	Yes	
<i>Respite Care in Home</i>	Home	Community Based Services	Respite care, in the home	Yes	
<i>Respite Care Outside of Home</i>	Other Place of service	Community Base d Services	Respite not in home per diem	Yes	If vendor not listed, add in notes

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Community-Based Services (continued)					
<i>Social Day Care</i>	Other Place of Service	Community Based Services	Center based day care per diem	Yes	
<i>Transportation</i>	Home or Other Place of service	Transportation	N-et; encounter/trip	Yes, non-emergency	
Day Habilitation	Other place of Service	Day Habilitation	Day habil waiver per diem	Yes	
Dental Services	Office or Outpatient Hospital	Dental Services	Dental consultation	Yes	Data enter specifics in Notes (root canal, dentures, bridge, etc)
Durable Medical Equipment (DME) and Medical/Surgical Supplies	Home	Durable Medical Equipment (DME) and Medical/Surgical supplies	Durable medical equipment mi or enter specific kind of DME-1)Wheelchair motorized w full 2)Hosp bed semi-elect w/ mattr 3) Wheelchair standard detach 4) Air fluidized bed 5) Air pressure mattress Etc 6) Diabetic custom molded shoe	Yes, May require Prior Authorization. Enter DME that costs \$200 or more	In notes, add type of DME if use requested service: Durable medical equipment mi
Hearing Aid Services	Office or Outpatient Hospital or Other Place of Service	Hearing Aid Services	1) Hearing aid check; binaural 2) Hearing aid check; monaural 3) Hearing aid noc 4) Hearing aid repair/modifying	Yes	

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Home Health (Certified)					
<i>Home Clinical Social worker</i>	Home	Home Health	HHCP-svs of csw,ea 15 min	Yes	
<i>Home Health Aide</i>	Home	Home Health	HHCP-svs of aide,ea 15 min	Yes	
<i>Home Occupational Therapy</i>	Home	Home Health	HHCP-serv of ot,ea 15 min	Yes	
<i>Home Physical Therapy</i>	Home	Home Health	HHCP-serv of pt,ea 15 min	Yes	
<i>Home Respiratory Therapy</i>	Home	Home Health	HH respiratory thropy nos/day	Yes	
<i>Home Skilled Nursing Care</i>	Home	Home Health	HHCP-svs of rn,ea 15 min	Yes	
Hospice					
<i>Hospice Facility</i>	Hospice	Hospice	Type Hospice in field and identify best option	Yes	
<i>Home Hospice</i>	Home	Hospice	Type Hospice in field and identify best option	Yes	
<i>Inpatient Hospital Hospice</i>	Inpatient Hospital	Hospice	Type Hospice in field and identify best option	Yes	
<i>SNF Hospice</i>	Skilled Nursing Facility	Hospice	Type Hospice in field and identify best option	Yes	

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Inpatient Hospital Services	Inpatient Hospital	Inpatient Hospital Services	Acute treatment	Yes – entered by CCA Clinical staff.	Specify details in the Notes Section (e.g. hip surgery, thyroid lobectomy)
Institutional Care (Skilled Nursing Facility or Comprehensive Inpatient Rehabilitation Center)	Skilled Nursing Facility or Comprehensive Inpatient Rehabilitation Center or Institutional Care	Skilled Nursing Facility or Institutional Care	Acute treatment	Yes – entered by CCA Clinical staff.	Enter as much detail as possible in notes section (e.g. approved at Sub acute for 2 weeks, custodial care)
Orthotics	Other Place of Service	Orthotics	Orthopedic shoe modifica NOS	Yes	
Oxygen and Respiratory Therapy Equipment	Home	Oxygen and Respiratory Therapy Equipment	Portable gas oxygen system	Yes	
Podiatry	Skilled Nursing Facility	Podiatry	Specialty Physician	No – except for services provided in a Nursing Home setting	In Notes section, enter Podiatry care
Prosthetic Services and Devices	Other Place of Service		Look up specifics related to Prosthetic and enter valid description	Yes	

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Therapy (Outpatient Rehab)					
<i>Outpatient Physical Therapy</i>	Comprehensive Outpatient Rehab Facility or Outpatient hospital or Other Place of Service	Physical Therapy	Physical therapy evaluation or Physical therapy re-evaluation	Yes	
<i>Outpatient Occupational Therapy</i>	Comprehensive Outpatient Rehab Facility or Outpatient hospital or Other Place of Service	Occupational Therapy	Occupational therapy evaluation or Occupational therapy re-evaluation	Yes	
<i>Outpatient Speech Therapy</i>	Comprehensive Outpatient Rehab Facility or Outpatient hospital or Other Place of Service	Speech and Hearing Therapy	Speech screening or Speech therapy, re-eval	Yes	
Non Contracted Providers/Vendors	Enter place of service (e.g. office, outpatient hospital, etc)	Use actual service category	Use actual requested service	Yes	Non contracted providers/vendors are not in CaseNET, Please enter Name, Address, Phone in Notes section.