Physician Portal Pre-Authorization

Manual/User Guide

Portal URL:

https://int.essettecloud.com/Providers/#/login

or

InetDr.com

For assistance with the Provider Portal, contact (281) 591-5289.

IntegraNet Health: http://www.integranethealth.com

HOUSTON OFFICE
2900 N. Loop West, Ste. 700
Houston, TX 77092
(281) 447-6800

DALLAS OFFICE
3010 LBJ Freeway, Ste. 1450
Dallas, TX 75234
(972) 764-0970

SAN ANTONIO OFFICE
736 So. Alamo St.
San Antonio, TX 78205
(210) 664-4020

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Utilization Management Provider Submission Process

I. Portal Access – creating an account

A. Complete the Portal Submitter Form at www.integranethealth.com/provider-registration

Or

Click on the authorization tab in the banner at the top of the page. Select: *Register for a New Account Here*

B. List all providers you may be entering authorization request or checking authorization status for in the "Entities to Affiliate With" section

C. Select your username

D. Submit online as directed.

E. Submitter must have a valid email address.

F. You will receive a secure email with your username and temporary password.

G. The first time you log in, you will receive a notification instructing you to reset your password. You will receive an email from **nonreply@hms.com** with the verification code needed to reset the password.

To rest or recover your password:

A. From landing page, select **forgot your password**.

B. Select **Request Password Reset** you will receive an email with a verification code and link to recover your password

C. Do one of the following:

a. Select the link in the email
b. Type or copy the verification code from the email in the **Verification Code** box
c. In the **New Password** box, type your new password.
d. In the **Confirm Password** box, re-enter your password
e. Select **Change Password.**

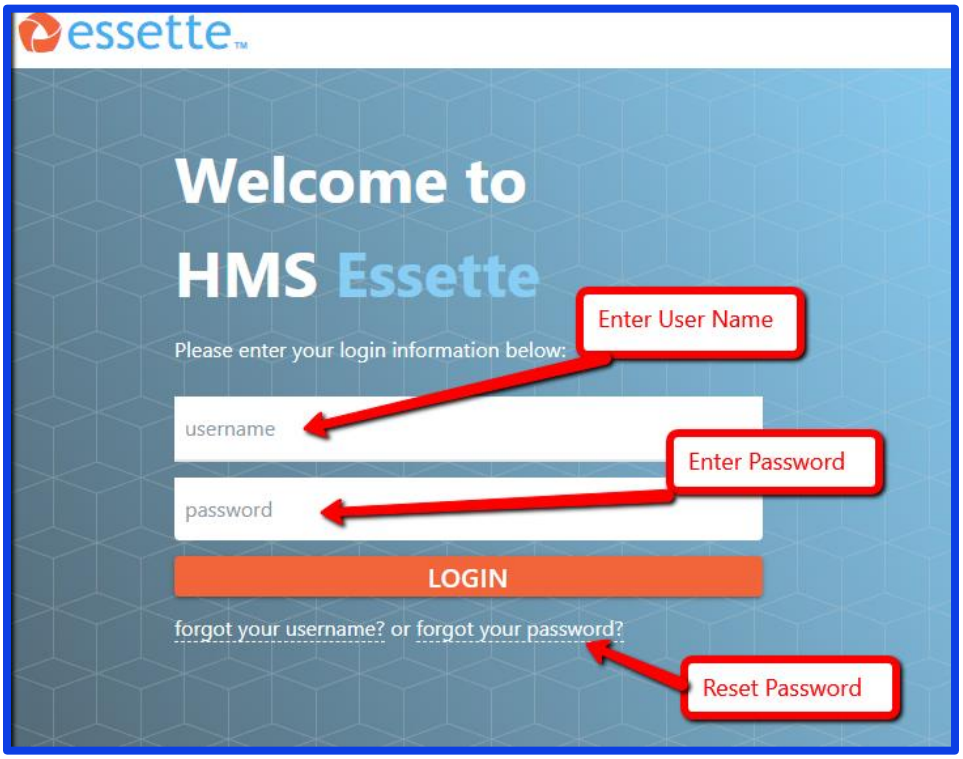
For assistance creating an account xxxx, or __-@___

II. Verify if a Procedure needs a Pre-Authorization

Check to see if authorization is required by visiting
https://providers.amerigroup.com/Pages/PLUTO.aspx

III. Log In

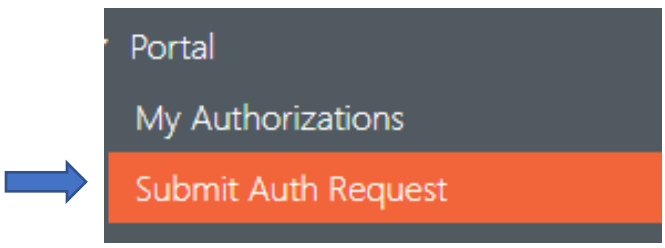
https://int.essettecloud.com/Providers/#/login



Must use Google Chrome

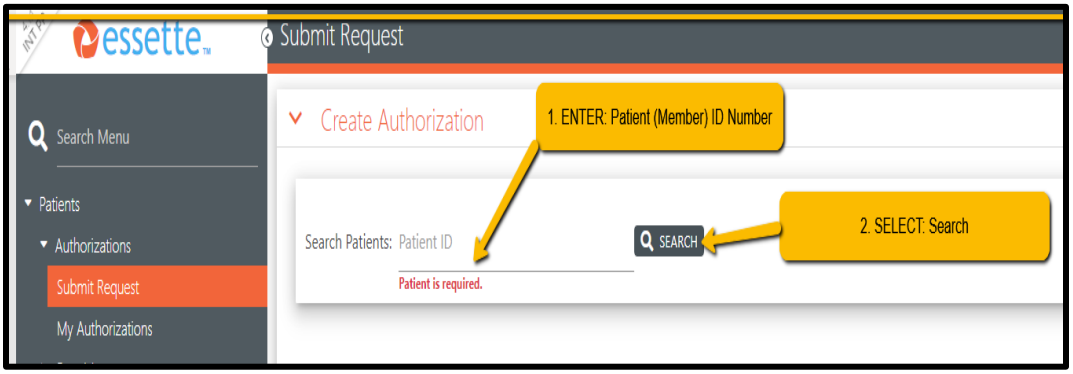
IV. Steps for submitting a Prior Authorization

A. Select Submit Auth Request
Left Side of the Screen



B. Portal Submission - Create Authorization

Step 1 – Select Member

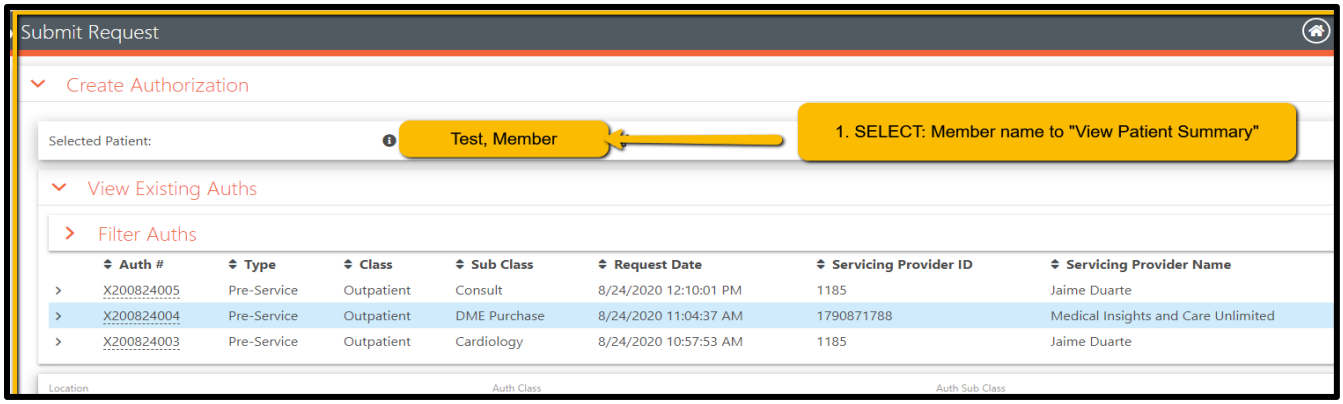


Enter Patient (Member) ID Number

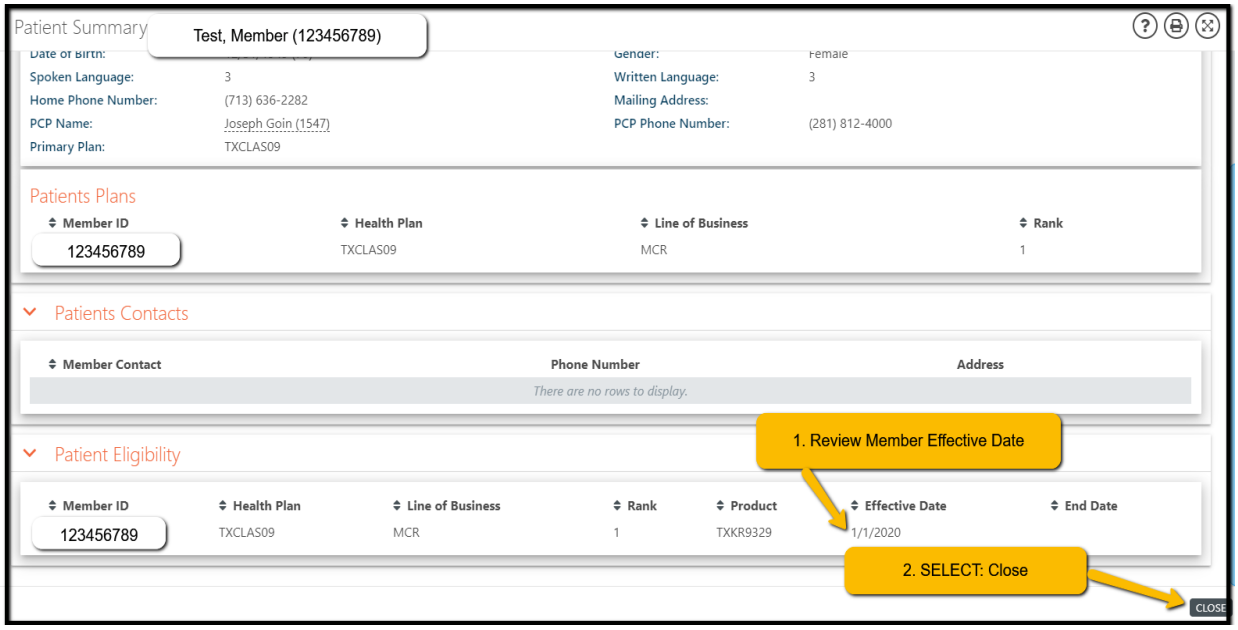
Select: Search

Step 2 – Check Member Eligibility

1. SELECT – Member Name to "View Patient Summary



2. A pop-up box will appear to view member eligibility. Summary can be printed if needed.



Step 3 – Provider and Class Details

Step 3- Continued

1. The Submit Request screen allows users to view existing authorization on file that are been submitted for requesting provider.

2. SELECT: Provider Location from drop down box. The Provider Location identifies the Provider who is requesting the authorization and/or making the referral.

3. SELECT: Auth (authorization) Class – choices include inpatient or outpatient

4. SELECT: Auth Sub Class – choices include, but are not limited to: cardiology, chemotherapy, DME rental, CT Scan, MRI, physical therapy, home health, injections, etc.

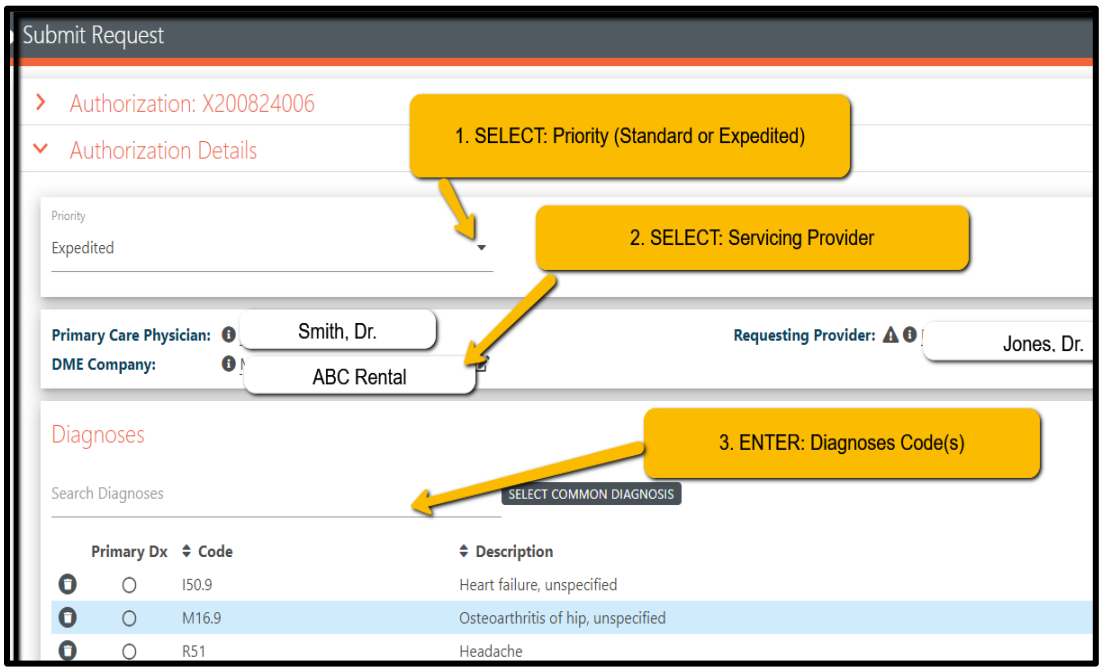
5. SELECT: Initial Service Date – A pop up calendar will appear, select the date the service will begin

6. SELECT: Type – is the requested service for Pre-Service, Concurrent Review or Post-Service (retro)

7. SELECT: + Create Auth

Step 4 – Authorization Details

1. SELECT: Priority (Standard or Expedited)



2.SELECT: Servicing Provider - can be searched by name or NPI

3.ENTER Diagnoses - Repeat step for all diagnoses added.

TIMEFRAMES

IntegraNet Health follows CMS guidelines for turn-around-times when making prior authorization determinations.

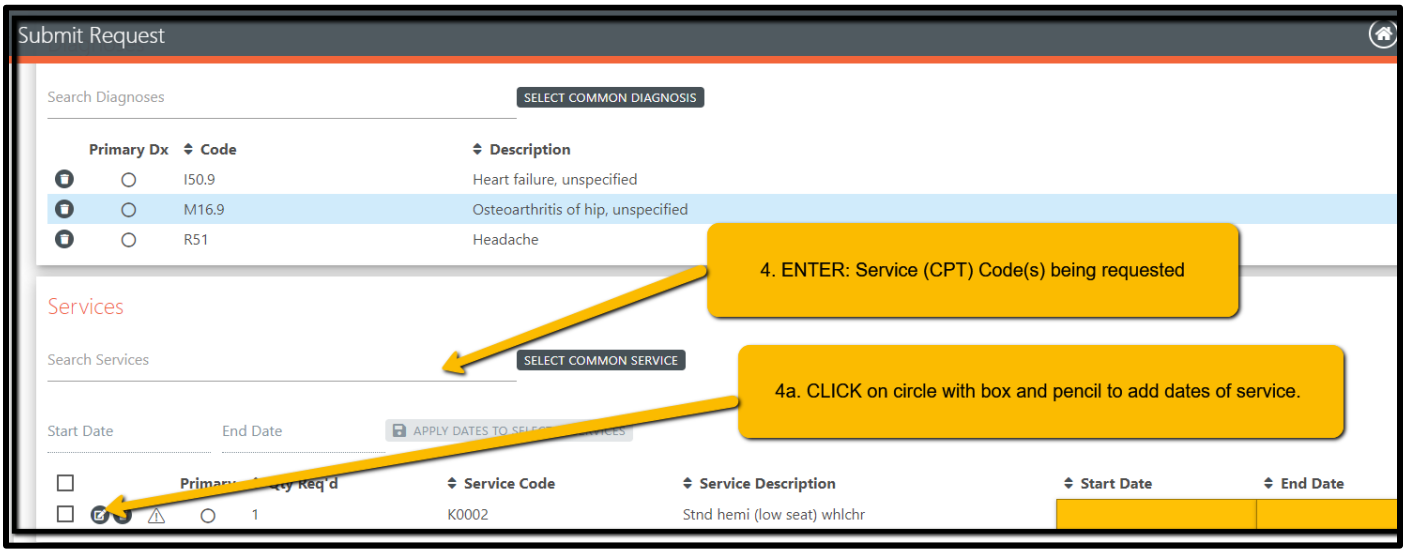
a. **Non-Urgent/Standard Request** – Per CMS, a standard determination is due within 14 days from date of receipt of the request. Prior authorization requests are reviewed and processed in the order they are received.

b. **Urgent/Expedited Request** – Per CMS, an expedited determination is due within 72 hours from date and time of receipt of the request. Prior authorization requests are reviewed and processed in the order they are received.

NOTE: Per CMS, an expedited determination should be requested when applying a standard time for making a determination could seriously jeopardize the patient's health, life, or ability to regain maximum function.

NOTE: Expedited determinations that do not meet the CMS definition will be denied an expedited determination and the standard timeframe will be applied. The provider and the member will be notified of the denial for expedited determination.

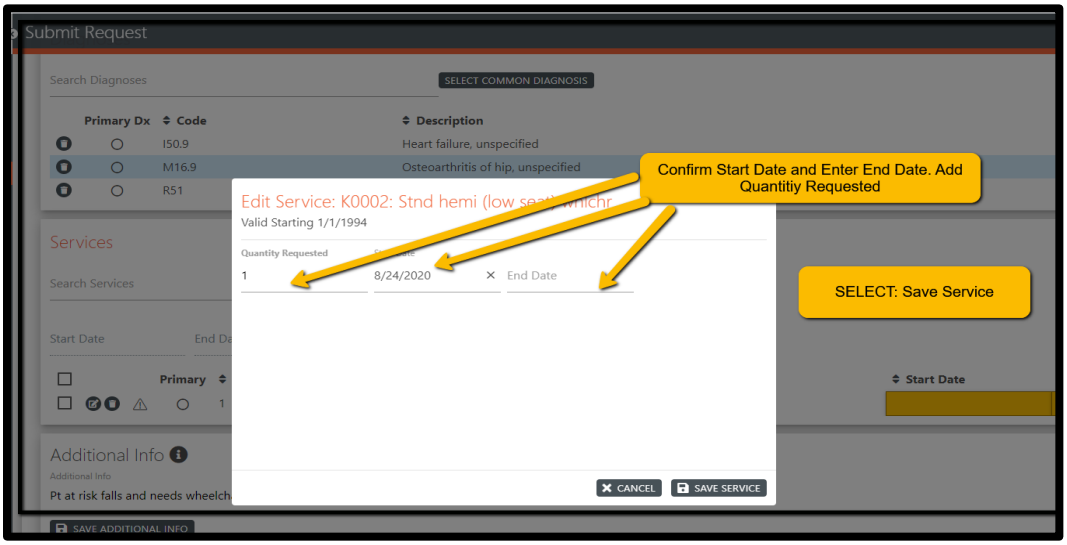
NOTE: Request for Expedited Determination must include the reason the for the urgent determination. The reason can be documented in the Additional Info section. See step 6 of this section.



4. ENTER Services – Enter the CPT code being requested. Repeat step for all codes

4a. ENTER -Start Date & End Date

ENTER Quantity - Add quantity requested (i.e. the quantity represents units, visits, or days).



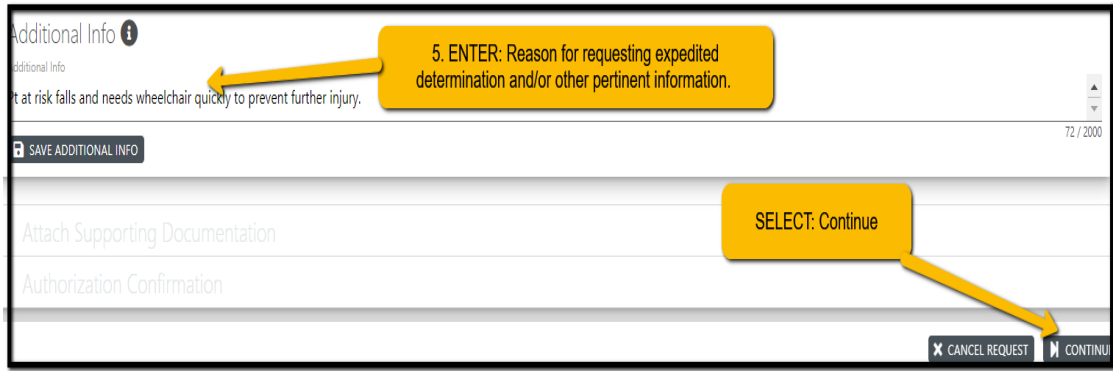
Click on the circle with the box and pencil to open the service date box. Save service.

Insert our rules on Units = x, visits= x. tell home health to use x, inpatient to use days, x to use visits., etc. – basic rule

Step 5 – "Additional Info"

ENTER:

1. The **reason for requesting an expedited determination**, if applicable.
2. This section can also be used to include additional pertinent information.
3. ***ENTER – Name and contact information of person submitting request.***

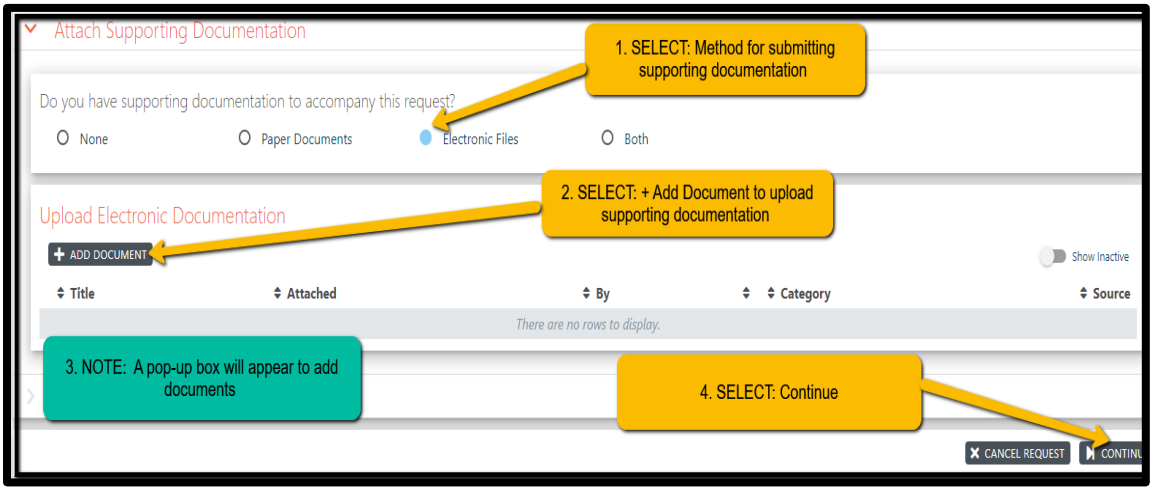


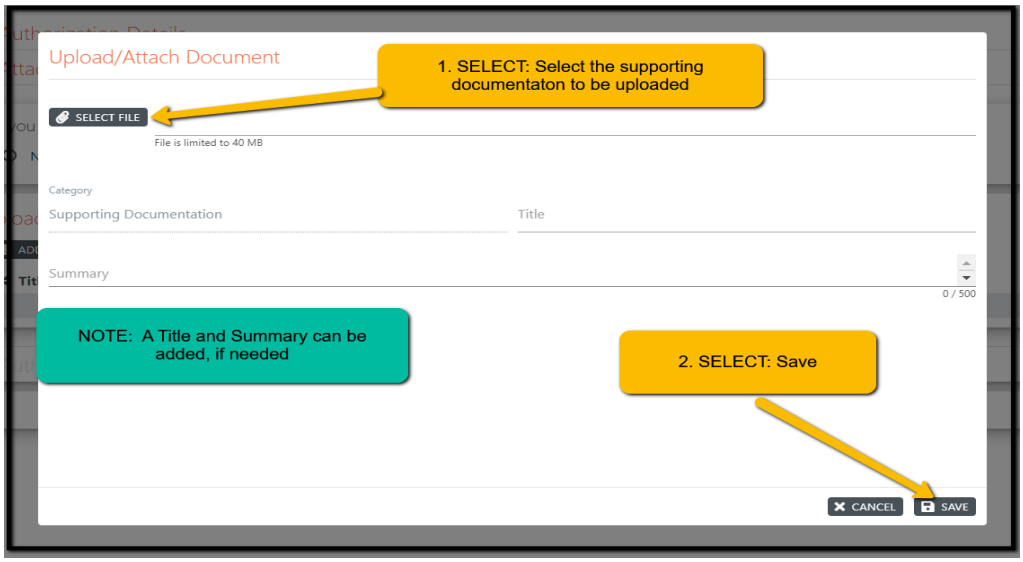
SELECT – Continue to advance to next screen

Step 6 - Attach Supporting Documentation

1. Select the method used to attach documents. Electronic files are preferred

2.Upload Electronic Documentation



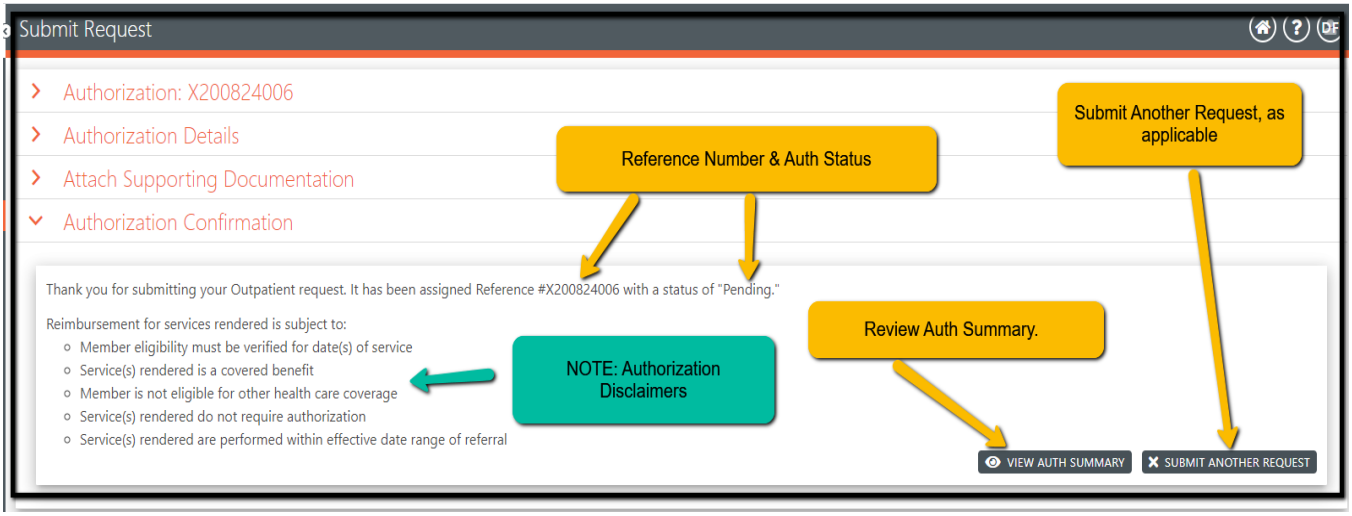


+ Add Document

Step 7 – Authorization Confirmation

1. The reference number and status can be viewed. The auth summary can be opened and printed for the patient's medical records.

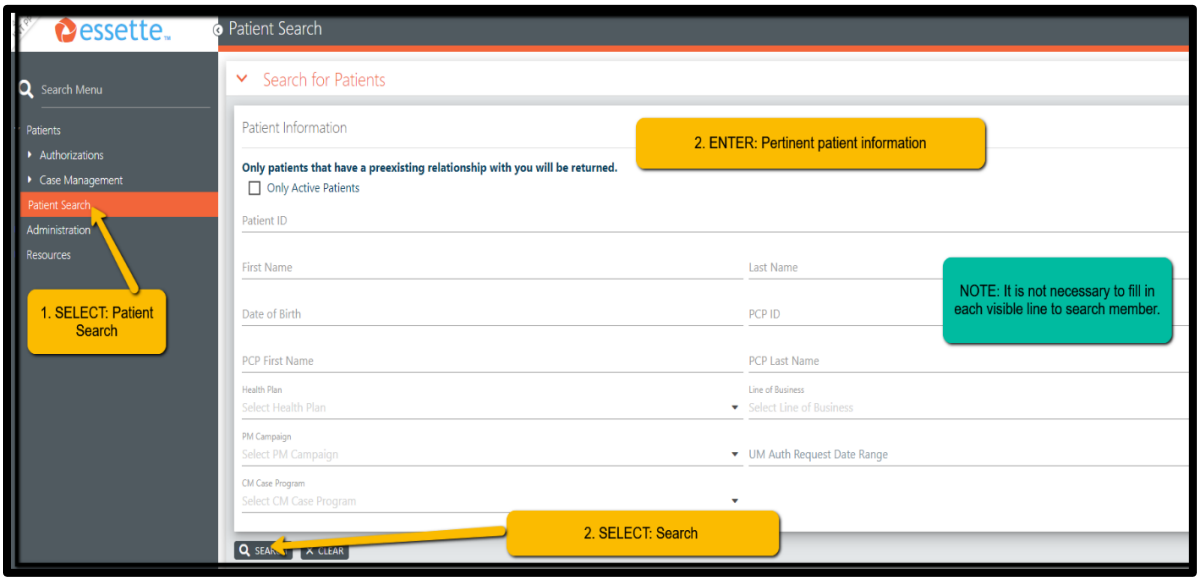
2. Click "Submit Another Request," as applicable.



V. SEARCH FOR PATIENTS

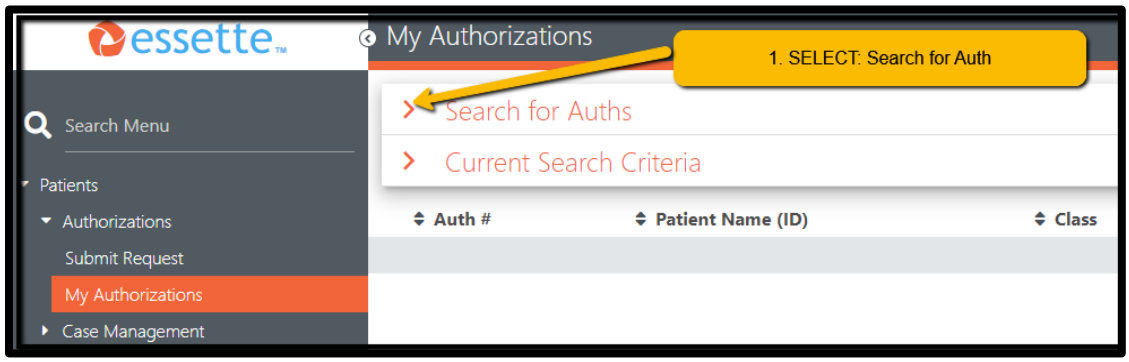
1. SELECT: Patient Search option from Search Menu Bar

NOTE: Only patients that have a preexisting relationship with you will be visible.

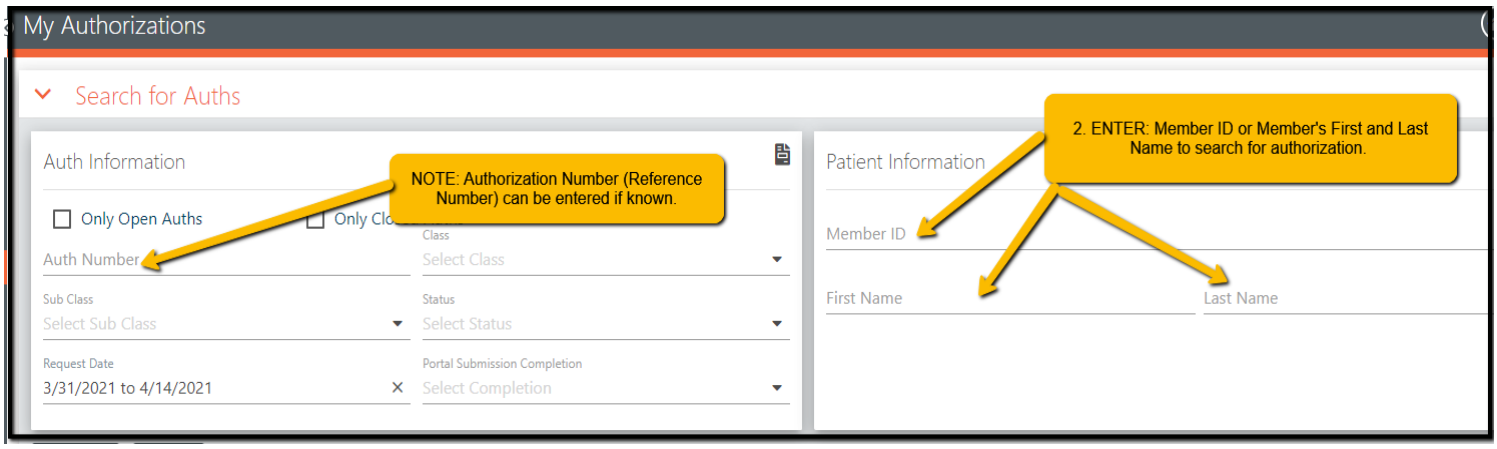


VI. CHECK AUTHORIZATION STATUS

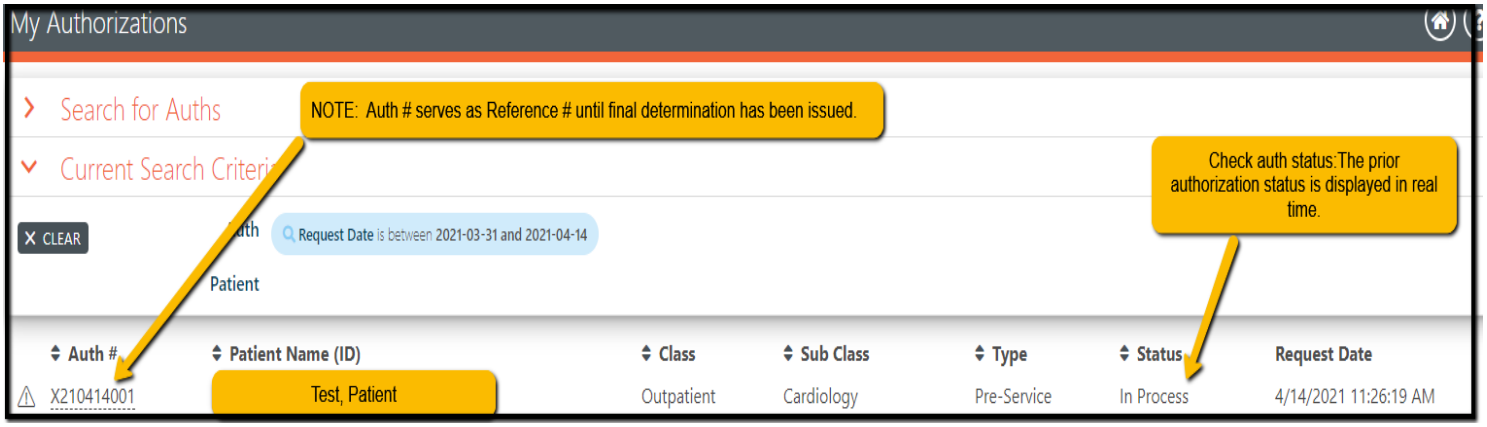
1. SELECT: Search for authorizations



2. ENTER: Member ID or Member's First Name and Last Name. Auth Number (Reference Number) can also be entered if known.



NOTE: Outstanding authorizations will also be visible from the "My Authorizations" Tab



VII. LOG OUT OF THE SYSTEM

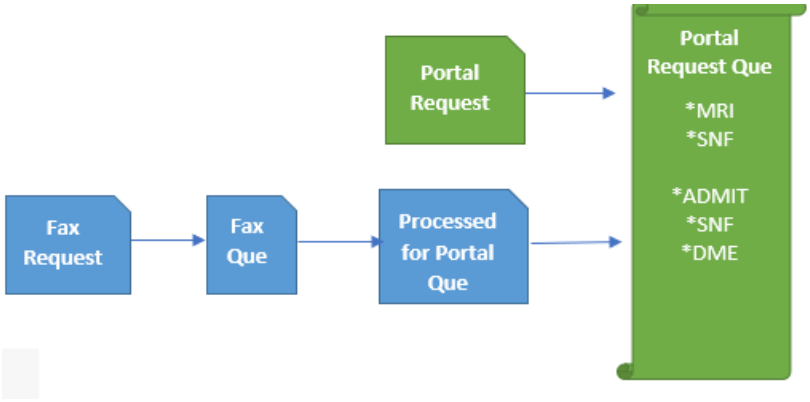
SELECT your initials in the top right corner to open box that allows you to log out.

Rev. 4-15-2021

REMINDERS

1. Authorization status can be checked 24/7 in the Provider Portal.

2. Request submitted in the portal by a provider maybe processed before a fax request.



3. Urgent request may take up to 72 hours to process from the date and time of submission into the Provider Portal, fax request may take longer.

4. Urgent request that do not meet criteria for an expedited request will be downgraded to Standard and processed accordingly.

5. Standard request may take up to 14 days to process from the date of submission into the Provider Portal, fax request may take longer.

6. Request are handled in the order they are received.

7. Precertification for coverage of selected standard outpatient and ancillary services with all supporting documentation should be submitted immediately upon identifying the need for the request 14 days prior to scheduling the service(s).

8. For assistance with the portal call (281) 333 - 1900
9. For concerns regarding an authorization, please call (281) 591 - 5289

10. To check if precertification is required go to:
https://providers.amerigroup.com/Pages/PLUTO.aspx