IntegraNet Health through our agreement with Amerivantage/Amerigroup –all Medicare Advantage Plans for members of our Primary Care Physicians are delegated to IntegraNet Health for Utilization Management.

Providers are solely responsible for and are strongly encouraged to verify authorization requirements **prior** to rendering service.

Initial Certification

**Initial prior authorization requests can be submitted by assigned Primary Care Physicians, Acute or Post-Acute Facilities.

**Recommendations from specialists for home health services must be approved and ordered by the patient's assigned Primary Care Physician.

- Submit prior authorization request to the IntegraNet Health Provider Portal at www.INETDR.com.
- The initial certification period can be requested without an OASIS/485: however, an order is required before an initial approval is issued.
    - To be considered medically necessary the physician must certify that:
        - The home health services are needed because the patient is confined to home;
        - The patient requires skilled nursing services, physical therapy or speech therapy on an intermittent basis;
        - A plan of care has been established and is reviewed by the physician;
        - The services are or were furnished while the patient is or was under the care of a physician; and,
        - A face-to-face encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason for the home health services and was performed by a provider.
- The initial approval for home health services without an OASIS/485 will be for 1-2 visits per discipline to allow assessment, completion, and submission of the OASIS/485.
- Upload the completed OASIS/485 to the initial authorization in the IntegraNet Health Provider Portal.
    - Indicate the number of units and visits being requested for the initial certification period in the NOTE SECTION of the Provider Portal. The UM staff will review the OASIS/485 for medical necessity and issue a determination based on criteria established by CMS.

Utilization Management
Home Health FAQ
Reference: Provider Manual

Recertification

- A decision must be made whether or not recertification is required following the initial 60-day certification or subsequent recertification periods.
- A plan of care must be reviewed and signed by the patient's Primary Care Physician (PCP) every 60 days unless the patient transfers to another home health agency or is discharged from services for meeting established goals and/or with no expectation of returning for services.
- Recertifications may be delayed if the plan of care is not reviewed, signed, and approved by the assigned PCP.
- To prevent delays in the recertification process, the PCP must have sufficient time to review, sign, and approve the plan of care.
- Submit the prior authorization request to the IntegraNet Health Provider Portal at www.INETDR.com
- Include the number of visits and units needed for each skilled discipline.
- Include the signed plan of care and any medically necessary supporting documentation.

NOTE: **When submitting the prior authorization request in the Provider Portal, the quantity requested (Qty Req'd) represents the number of units being requested for each discipline. Number of visits requested can be documented in the NOTE SECTION of the Provider Portal.**

Example	Quantity of Visits is requested in units 1 visit = 4 Units, e.g. 2 visits = 8 units, 3 visits = 12 units	G0299
		G0300
		G0152
		G0153

REMINDERS

- Recertification must be requested prior to the expiration
- Must have Primary Care Physician Approval
- Recertifications generate a ***new*** authorization number
- Additional visits/units can be added during a certification period per skilled discipline with appropriate signed MD order and/or evaluations/re-evaluations

NOTE: IntegraNet follows CMS guidelines for determination turn-a-round times. Standard requests can take up to 14-days. Expedited requests can take up to 72 hours. Expedited requests that do not meet the CMS definition for an expedited determination will be downgraded and the standard timeline applied.

The Provider Portal can be used to check status of prior authorization requests.

Amerigroup's PLUTO tool can be used to determine the possible authorization requirements
https://providers.amerigroup.com/Pages/PLUTO.aspx ** this tool is NOT a guarantee of coverage**

Utilization Management Services: (281) 591-5289
Problems with the Portal submit a web-ticket (not for authorization request): https://inetclaims.zendesk.com

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