




Prior Authorization/Utilization Management FAQs

Provider Toll Free: 844-575-4387


[For directions on how to enter an authorization, click on this link.](#)

Frequently Asked Questions and Answers


 **Q: What is the process flow for expedited (urgent) authorizations?**

 **A:** Expedited (urgent) requests should be submitted telephonically using the Provider Toll Free Number above, then Press 1 to be directed to the Utilization Management department.


 **Q: Will phone lines be answered or will calls go into a voice mail que?**

 **A:** All calls will attempt to be answered during standard hours: Monday – Friday 8:00 AM to 6:00 PM. Depending on call volume, UM reviewers may be on another call; however, confidential voice mails may be left and UM personnel will return your calls accordingly, prioritizing calls while striving to return calls within one (1) business day.

 **Q: What is standard turnaround time for prior authorization requests?**


 **A:** Depending on request volume and type of request, our goal for request review turnaround is within three (3) business days of request. CMS allows 14 days for standard request reviews and 72 hours for expedited (urgent) request reviews, unless VHP notifies the provider and member of our decision to extend our review by up to 14 additional calendar days to make an organization determination based on specific reasons for extension. VHP prioritizes requests based on urgency, type and timing of request.

 **Q: Can prior authorization requests be done online?**


 **A:** Yes – this feature can be found on the Provider Portal. See steps to use this system on page 3 of this reference document. Portal request authorization numbers are not final approvals and UM personnel must finalize the review within our clinical system and provide the Requesting Provider with the final authorization number to be referenced. Portal submissions should include supportive documentation that can be attached to the submission. UM personnel may reach out to the provider for additional information to process the portal request.

Providers should ensure that all appropriate information has been submitted using provided drop down and search features to support authorization submission. The Provider Portal authorization section also allows for providers to look up codes to determine if an authorization is required for the specific procedures or service.


 **Q: What process should a provider follow when they disagree with an authorization decision?**

 **A:** Vibra will defer any authorization requests that do not meet Interqual criteria, NCD/LCD (if Interqual not available), and/or established Medical Policy to Medical Director for review. If denied, Member has appeal rights and the member may authorize the Provider to act on their behalf in appealing the decision.


 **Q: What is process for Appeals?**

 **A:** Send Appeal to the Appeals & Grievances Dept: ATTN: Appeals & Grievances
P.O. Box 60250
Harrisburg, PA 17106-0250
Fax: 1-844-774-5585 / Phone: 1-844-575-4385


 **Q: What is the process for providing additional clinical information?**

 **A:** Providers can send in additional clinical information via the UM fax line at 844-303-0324, via postal mail, or via e-mail at um_fax@vibrahealthplan.com. Photos must be mailed.


 **Q: What is the process for reporting an inpatient Observation status? Can Observation be approved/billed if IP denied?**

 **A:** Provider must call within 48 hours of determination to place member in observation status. Observation can be approved/billed if member has been notified of their Observation status. Member will be subject to standard OP single Copay and applicable coinsurance.


 **Q: What happens on the weekend and at night if the emergency department has an expedited service request/discharge etc.? What if they have a question about UM on the weekend?**

 **A:** Non-urgent questions about UM should be handled during normal business hours, Monday thru Friday, 8AM - 6PM. Urgent / expedited requests should be directed to the toll-free number above, then press 1 to be directed to the Utilization Management Department. Confidential voice mail can be left and a return response will be provided.

 **Q: What is process for pre-determinations?**

 **A:** A predetermination is a voluntary, written request by a provider to determine if a proposed treatment or service is covered under a patient's health benefit plan and follows the standard review process. Provider and member will be notified of final determination.

 **Q: What is process for retrospective reviews?**

 **A:** Retrospective review requests shall be limited to services that have been performed within sixty (60) days prior to the submission date of review request to Vibra Health Plan where a claim has not been submitted. Failure to obtain preauthorization for a service could result in payment reductions for the provider and benefit reductions for the member, based upon the provider's contract and the member's Evidence of Coverage. Services or medications provided without preauthorization may be subject to retrospective medical necessity review.

VHP WEBSITE PROVIDER PORTAL PRIOR AUTHORIZATION ONLINE STEPS

IMPORTANT: URGENT AUTHORIZATIONS ARE NOT ACCEPTED THROUGH THE PROVIDER PORTAL AND MUST BE CALLED OR FAXED TO OUR UTILIZATION MANAGEMENT DEPARTMENT

STEPS FOR ENTERING AN AUTHORIZATION IN THE PROVIDER PORTAL

Step 1: Log into www.vibrahealthplan.com

Step 2: Click on “For Providers” at top near center of page

Step 3: Click on “Sign In” in center of page

Step 4: Enter Username and Password to access the secure Provider Portal

Step 5: Click on “Authorizations” in ribbon bar. Note: It may take 1-2 minutes to load the Authorization page.

Step 6: Determine if you wish to look up if a code requires authorization, search for a submitted request, or submit an authorization.

To Determine a Code Requires an Authorization, click on “Submit an Authorization” link under “Submit a new authorization”. Before you start the authorization entry, enter code in look up field and select code from drop down list that presents as code is typed in.

To Look Up a Submitted Request, click the “Submitted Requests” radio button, then enter dates of service/request. Hit the Search button.

To Submit an Authorization, click on “Submit an Authorization” link under “Submit a new authorization”.

Step 7: To start an authorization, select the authorization template which best suits your individual request. Options include:

- Inpatient Admission
- Inpatient Behavioral Health
- Inpatient Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Inpatient Long Term Acute Care Facility
- Observation
- Outpatient Behavioral Health
- Outpatient Surgery
- Comprehensive Outpatient Rehabilitation Facility
- Outpatient Therapy
- Home Health Services
- Advanced Imaging
- Durable Medical Equipment
- Medical Injectables
- Laboratory
- Transport, Non-Urgent Outpatient

Step 8: After selecting the desired authorization template, enter the member's Vibra Health Plan (VHP) ID number and click "Add This Member". If member's VHP ID is not available, you may search for a member by clicking on "Search for a Member".

Step 9: Once member information loads, confirm you have selected the appropriate member by reviewing the member's name, address, date of birth and eligibility date.

Step 10: Enter Referring Provider using either Provider Name or NPI number. Once name or number is entered, click "Find Provider" and click to "Add This Provider". If you need to search for a provider name, enter name and click on "Find Provider". Select provider from list provided by clicking the "Add This Provider" next to the appropriate provider's name.

Step 11: If Servicing Provider is the same as Referring Provider, simply click designated check box. If Servicing Provider is different from the Referring Provider, enter Servicing Provider using either Provider Name or NPI number. Once name or number is entered, click "Find Provider" and click to "Add This Provider". If you need to search for a provider name, enter name and click on "Find Provider". Select provider from list provided by clicking the "Add This Provider" next to the appropriate provider's name.

Step 12: If Referring Provider is the same as Facility Provider, simply click designated check box. If Facility Provider is different from the Referring Provider, enter Facility Provider using either Facility Name or NPI number. Once name or number is entered, click "Find Provider" and click to "Add This Provider". If you need to search for a provider name, enter name and click on "Find Provider". Select provider from list provided by clicking the "Add This Provider" next to the appropriate provider's name.

Step 13: If available, enter Place of Service using drop down option.

Step 14: Add Diagnosis Code(s) by entering Primary Diagnosis Code and date of diagnosis along with any secondary diagnoses that support request.

Step 15: Add Date(s) of Service including From and To dates.

Step 16: Add Service Code(s) by entering procedure code and number of units as appropriate for entered code. If additional codes are needed, click "Add Service" button and enter additional code(s) and unit(s). Do not click "Add Service" button if you do not wish to add any additional codes.

Step 17: If documents require submission, (i.e., admission face sheet, therapy records, DME physician order, etc.), attach document by clicking "Choose File" and selecting appropriate file(s) to be added.

Step 18: Upon completion of these steps, click "Submit Request". You may cancel your request at any time by clicking on "Cancel Request" or to start over authorization process.