Vermont Act 111 (Bill H.766)
Changes effective January 1, 2026: Claims Editing
Frequently Asked Questions

Background

Vermont Act 111 requires health insurers to ease prior authorization, step therapy, and billing requirements for certain primary care services and prescriptions. Following state guidance, MVP will adjust procedures with Participating Providers to comply with this law. This summary outlines how MVP will implement these changes to support your practice.

Effective January 1, 2026, MVP will revise its claims editing procedures to ensure compliance with applicable legislation. Claims editing must adhere to established national standards, including the CMS National Correct Coding Initiative and Medicare Code Editor. Furthermore, edits may only be implemented on a quarterly basis, with prior notification provided to healthcare providers. The law also establishes restrictions on prepayment of coding validation and affirms that health plans retain the authority to deny or audit claims when appropriate. These requirements are applicable exclusively to providers authorized within Vermont. You can find more details about this update in the FAQ section below.

Q: What is claims editing? How does Act 111 impact health plan claims editing practices?

"Claims editing" is the process that health plans use to review submitted claims for consistency with CMS and AMA medical coding guidelines.
"Editing" is when one or more adjustments are made to CPT codes, American Society of Anesthesiologists' (ASA) current procedural terminology, the American Dental Association's (ADA) current dental terminology, or Healthcare Common Procedure Coding System (HCPCS) Level II codes included in a claim that result in:

- Payment being made based on some, but not all, of the codes originally billed by a participating health care provider
- Payment being made based on different codes from those originally billed by a participating health care provider;
- Payment for one or more of the codes included in the claim originally billed by a participating health care provider being reduced by application of payer's editing software, such as multiple procedure logic software;
- Payment for one or more of the codes being denied;
- A reduced payment as a result of services provided to an insured that are claimed under more than one procedure code on the same service date

Health plan payment policies and manuals do not constitute edits or claims editing under Vermont law.

Health plans must limit claims editing to the following standards, processes, and guidelines:

- The CMS National Correct Coding Initiative (NCCI) as in effect for Medicare for claims for outpatient and professional services.
- The CMS Medicare Code Editor as in effect for Medicare for facility claims.
- Appropriate nationally recognized edit standards, guidelines, or conventions for pharmacy claims.

Q: What if Medicare changes an applicable edit standard, process, or guideline?

Health plans are required to apply the relevant edit standards, processes, and guidelines from NCCI or Medicare Code Editor in effect on the date the claim is submitted.
If Medicare changes an edit standard, process, or guideline within 90 days prior to the date the claim is submitted, health plans can use the prior version of the edit standard, process, or guideline if it has not yet updated its claims processing system.

Q: Can health plans use other claims editing standards?

Health plans can use other claims editing standards in certain situations:

- When use of other claims' editing standards is necessary to comply with State or federal laws, rules, regulations, or coverage mandates.
- When use of other claims editing standards is more favorable to providers than the NCCI or Medicare Code Editor.
- To address new codes that are not yet incorporated into a health plan's claims processing system.

Q: When can health plans release new edits?

Not more than quarterly, to take effect on January 1, April 1, July 1, or October 1.
New edits must be filed with the Department prior to implementation. Health plans must also give providers at least 30 days' advance notice prior to implementation.
If Medicare changes an edit standard, process, or guideline, health plans must incorporate those modifications into their next quarterly release of edits.

Q: Can health plans review submitted claims for correct coding prior to adjudication?

Health plans may not require providers to submit medical record documentation to adjudicate a claim as part of a prepayment coding validation edit review, unless it is targeted to a specific provider or provider group for the purposes of:

- Evaluating "high-dollar" -payable claims over $100,000
- Verifying complex financial arrangements.
- Investigating member questions.
- Conducting post-audit monitoring.
- Addressing a reasonable belief of fraud, waste, or abuse.
- Other circumstances determined by the Department.

Q: Does Act 111 prohibit health plans from denying claims during adjudication?

No, it does not prohibit health plans from denying a claim during adjudication if the health plan determines that a billed item, service, treatment, or procedure is not medically necessary, experimental or investigational, or otherwise excluded from coverage under the terms of its subscriber contract with its member.

Q: Does Act 111 prohibit health plans from auditing paid claims?

Act 111 does not prohibit health plans from auditing paid claims after adjudication.

Q: Do Act 111's limitations on claims editing and provider notice requirements apply to providers outside of Vermont?

Limitations do not apply to providers that are not licensed, certified, or otherwise authorized by law to provide health care services in Vermont.

- **More information can be found on the MVP website.**
- **Also review the state of Vermont Frequently Asked Questions document.**