Vermont Act 111 (Bill H.766)

MVP Health Care® (MVP) is committed to keeping Providers informed of changes that impact their practice and patients. One such change is Vermont Bill H.766, signed into law as Act 111. Health insurers are required to reduce certain prior authorization, step therapy and insurer billing requirements for primary care services and prescription drug step-therapies under specific conditions in an effort to improve delivery of care. Based on guidance issued by the Vermont Department of Financial Regulation (DFR), MVP is changing the way we do business to better work with Participating Providers. This summary has been prepared for you on how MVP will implement the new legislation and support your practice.

Table of Contents

Waiver of Prior Authorization Requirement

Eligible Primary Care Provider (PCP)

Qualifying Member

Qualifying Service

Provider Claims Submission for Waiver of Prior Authorization

Step Therapy and No Prior Authorization for Inhalers

Policy Notifications

Claims Editing

Waiver of Prior Authorization Requirement

Beginning January 1, 2025, the prior authorization requirement will be waived on a Qualifying Service when it is ordered by an Eligible Primary Care Provider for a Qualifying Member.

Eligible Primary Care Provider (PCP)

An Eligible Primary Care Provider (PCP) is a provider listed on the Vermont Blueprint for Health monthly roster by individual NPI and is a contracted and credentialed provider with MVP Health Care.

Qualifying Member

A Qualifying Member is an active MVP Member that is enrolled in a Vermont fully-insured Qualified Health Plan (QHP).

Qualifying Members can be identified in the following ways:

Electronic Eligibility

"VT" may be indicated in the 2100C loop (Subscriber/Insured Name) REF (Subscriber Additional Identification) 6P (Group Number) segment of the 271 transactions.

Example:

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REF*6P*600000*VT INDIVIDUAL EXCHANGE GROUP~
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Provider Account

In the Member Eligibility details, "Vermont" is listed in the "Group State" field.

Example:

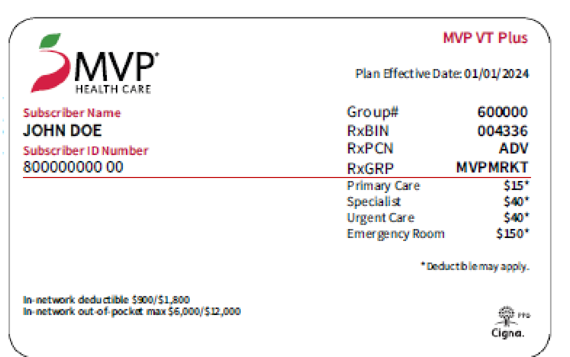
Group:	200039 - ANDY BONNEAU MACHINERY
Group State:	VERMONT
Date of Birth:	02/15/1963
Product Name:	FRVT STD PLATINUM
Coverage Type:	Subscriber Only
Product ID:	HX002105
Line of Business:	HMO
Recertification Date:	N/A
HRA:	N/A
Other Insurance Carrier:	N/A
Effective:	N/A
Order Applied:	N/A

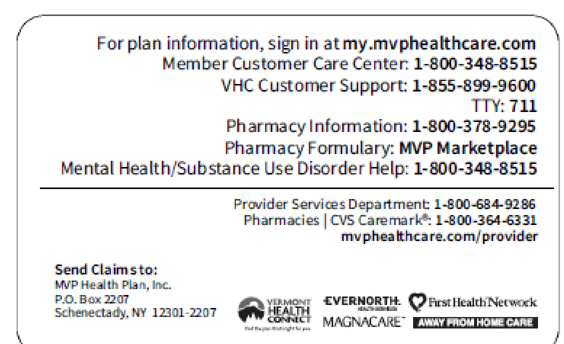
COB DETAILS

Member ID Card

"VT" is indicated in the upper right corner on the front of the ID card and the VHC Customer Support number is listed on the back.

Example:





Members enrolled under an MVP New York based plan or a self-funded Administrative Services Only (ASO) plan are not eligible for the prior authorization waiver.

Qualifying Service

A Qualifying Service is a Covered Service under the Member's subscriber contract (admission, high tech imaging, clinical laboratory test, durable medical equipment, etc.) within an ordering PCP's scope of practice and licensure and provided by an in-network Provider.

Provider Claims Submission for Waiver of Prior Authorization

When billing for a qualifying service ordered by an eligible PCP for a qualifying Member, use the guidelines below for the system to automatically bypass the prior authorization requirement.

Electronic Submissions

- **Electronic 837P** (professional) – Use loop 2420E, enter the qualifier DK
- **Electronic 837I** (institutional) - Use loop 2310E, enter the qualifier DK followed by the ordering Provider's NPI with no spaces (Ex: DK9876543210)

CMS 1500 Form Paper Claim Submissions

- **Field 17** – Enter the qualifier DK and the full name and credentials of the eligible ordering Provider
- **Field 17b** – Enter "NPI" to the left and the eligible ordering Primary Care Provider's NPI number to the right

UB-04 Paper Claim Submissions

- **Form Locator 78 or 79** (Additional Provider Information) - Enter the qualifier DK followed by the ordering provider's NPI with no spaces (Ex: DK9876543210)

Only in-network qualifying services are eligible for a prior authorization waiver. Prescription drugs and out-of-network admissions, treatments, services, items will continue to require Prior Authorization.

MVP may perform retrospective review and deny a claim during adjudication if it is determined that a billed item, service, treatment, or procedure is not medically necessary, experimental, investigational, or otherwise excluded from coverage under the Member's subscriber contract.

Step Therapy and No Prior Authorization for Inhalers

Health plans must grant exceptions for prescription drug step therapy requirements under certain circumstances and must allow at least one readily available asthma control medication from each class of medication and mode of administration without prior authorization.

Policy Notifications

Health plans must notify Participating Providers of any change to an existing policy or manual in writing at least 60-days prior to its effective date, during which time Providers can object in writing by emailing comments@mvphealthcare.com, and plans must respond. This does not apply to quarterly updates for CPT and HCPCS coding or payment updates and does not include Medical, Pharmaceutical or Formulary updates, which will continue to be communicated 30-days prior to implementation.

Claims Editing

Vermont has deferred the claims editing section of Act 111 until January 1, 2026.

Please note: This information is subject to change based on guidance issued by the Vermont Department of Financial Regulation (DFR). As changes or updates become available, MVP will keep Participating Providers informed with FastFax communications and through the Important Updates section of the MVP Communications Center.