Act 111: Claims Submission Requirements for Waiver of Prior Authorizations

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IMPORTANT NOTE: The information below is preliminary to assist with your planning efforts. The information is subject to change per final guidance from the Department of Financial Regulation (DFR).

Beginning January 1, 2025, prior authorizations will be waived for eligible primary care providers who order a qualifying service for a qualifying member.

When billing for a qualifying service, such as imaging services, clinical laboratory services, durable medical equipment, prosthetics, orthotics, and supplies, ordered by an eligible provider for a qualifying member, there are specific claim submission requirements. The details for claim submission are outlined below (see page 2) and must be followed for the claim to bypass the prior authorization requirements automatically.

Provider Requirements for Prior Authorization Waiver

- Must participate in Vermont Blueprint for Health.
- Must be enrolled, credentialed, and contracted with Blue Cross and Blue Shield of Vermont.

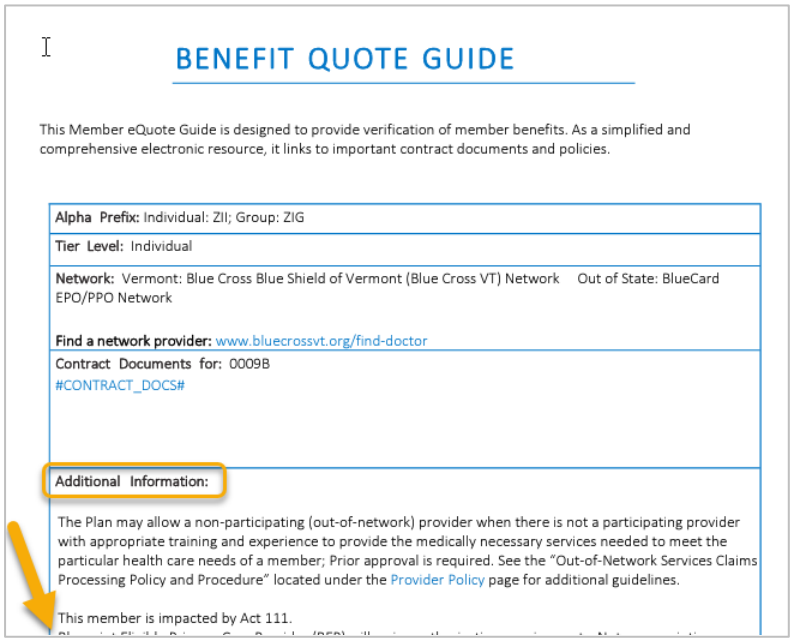
Note: While the provider does not need to be the Blue Cross VT member's selected primary care provider, the ordering provider must have engaged in clinical decision making for the ordered service.

Only in-network services are eligible for a prior authorization waiver. Out-of-network services and prescription drugs require prior authorization.

Member Requirements for Prior Authorization Waiver

- The member is enrolled in a Qualified Health Plan, a large group fully insured plan, New England Health Plan/Access Blue New England, or a governmental plan (State of Vermont, University of Vermont, Vermont Education Health Initiative). Members enrolled in the following plans are not eligible for the prior authorization waiver: non-governmental, federal employee (prefix of “R”), BlueCard (other Blue Plans), Medicare Supplement, or Medicare Advantage.
- You can identify eligible members by any of the following ways:
    - In a 27X transaction, a “YES” after the product name in the EB05 area means the member is eligible for a prior authorization waiver (see image below).

- The member's group number on their member ID card is listed in our online Act 111 Prior Authorization document.
- Within the eQuote local eligibility area of the Provider Resource Center, there will be a call out in the Additional Information section (see image below).



Claims Submission Process

If you are the rendering and eligible ordering provider submitting a claim for a qualifying service (i.e., an imaging service, clinical laboratory, or durable medical equipment, prosthetics, orthotics and supplies) for a qualifying member, you must follow the below claim submission process for it to bypass the prior authorization requirements automatically.

If you are a rendering provider submitting a claim for an eligible ordering Vermont Blueprint for Health primary care provider for a qualifying service for a qualifying member, you must follow the below claim submission process for it to bypass the prior authorization requirements automatically.

CMS 1500 PAPER CLAIM FORM

Item Number 17

Qualifier: DK ORDERING provider – enter to the left of the dotted vertical line.
Name: enter first name, middle initial, last name, and credentials to the right of the dotted vertical line.

Example:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

DK | Jane A. Smith MD

Item Number 17b

Enter NPI to the left of the dotted vertical line and the NPI number of the ORDERING eligible Primary Care Provider to the right of the dotted vertical line.

Example:

17b. | NPI | 0123456789

UB 04 PAPER CLAIM FORM

Form Locator 80 - REMARKS

Definition: Area to capture additional information necessary to adjudicate the claim.

Populate line 1 with qualifier DK (ordering provider) immediately followed by the ordering provider's NPI number.

Example:

80 REMARKS

_____

DK9876543210

ELECTRONIC 837P (professional) CLAIM SUBMISSION

Complete loop 2420E and use qualifier DK

You will want to follow up with your vendor(s) and/or clearinghouse(s) to find out how to get these details into your claim transactions.

ELECTRONIC 837I (institutional) CLAIM SUBMISSION

Use loop 2300, populate with a DK and ordering provider's NPI with no spaces, for example: DK9876543210

You will want to follow up with your vendor(s) and/or clearinghouse(s) to find out how to get these details into your claim transactions.

Claims Processing Questions for Prior Authorization Waivers

If your claim is denied and the qualifying service was ordered by an eligible Vermont Blueprint for Health primary care provider for a qualifying member, contact Customer Service for a claim review by calling (800) 247-2583 or emailing customerservice@bcbsvt.com.