VERMONT

State of Vermont
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620-3101

For consumer assistance:
[Banking] 888-568-4547
[Insurance] 800-964- 1784
[Securities] 877-550-3907

www.dfr.vermont.gov

Vermont Department of Financial Regulation

Division of Insurance

Insurance Bulletin No. 178

Revision of 18 V.S.A. § 9418b(g)(4) time frame for responding to a non-urgent prior authorization request and related clarifications

Purpose of Bulletin

The purpose of this Bulletin is to (1) notify all health plans, as defined in 18 V.S.A. § 9418(a)(8), as well as managed care organizations subject to Regulation H-2009-03 and Vermont-licensed mental health review agents subject to Regulation H-2011-01, of a law enacted during the 2013 Session of the General Assembly that amends Section 11h of Act 171 of 2012 relating to the time frame for responding to a non-urgent prior authorization request from a prescribing health care provider; and (2) clarify the unchanged portions of Section 11h.

Time Frame for Responding to Non-Urgent Prior Authorization Requests

Pursuant to Section 5a of Act 79 of 2013, An Act Relating to Health Insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board, a health plan, managed care organization, or mental health review agent must respond to a completed prior authorization request from a prescribing health care provider within **two business days** of receipt for non-urgent requests. Section 5a of Act 79 of 2013 amended 18 V.S.A. § 9418b(g)(4) and became effective on June 7, 2013.

Previously, under Section 11h of Act 171 of 2012, which added 18 V.S.A. § 9418b(g)(4), a health plan, managed care organization, or mental health review agent had 120 hours to respond to a completed prior authorization request from a prescribing health care provider for non-urgent requests.

Weekends and legal holidays, as defined in 1 V.S.A § 371, do not count as business days. Non-urgent requests received after normal business hours are deemed to have been received on the next business day.

All prior authorization requests related to mental health and substance abuse conditions, pharmacy benefit determinations, determinations about whether the use of a prescription drug for the treatment of cancer is medically necessary, or requests that are designated as urgent by the member or the member's health care provider, are treated as urgent unless otherwise specified in Regulation H-2009-03, §3.2(B).

Clarification of Unchanged Portions of 18 V.S.A. § 9418b(g)(4)

The time frame for responding to urgent prior authorization requests remains 48 hours. Weekends and holidays, both legal and non-legal, are not exempt from the 48 hour time frame.

Additionally, the requirement that a health plan, managed care organization, or mental health review agent acknowledge receipt of both urgent and non-urgent prior authorization requests within 24 hours remains unchanged. "Acknowledge" means to notify a health care provider of or make available to a health care provider a written receipt of the prior authorization request, through email, fax, or any other written means that can be accomplished within 24 hours. This requirement is separate from the oral and written determination notice requirements contained in Regulation H-2009-03.

Finally, the portion of 18 V.S.A. § 9418b(g)(4) providing that if a health plan, managed care organization, or mental health review agent does not respond to a completed prior authorization request, acknowledge receipt of the request for prior authorization, or request missing information within the relevant time frame, the prior authorization request is deemed to have been granted, remains unchanged. Even under the new time frame for non-urgent requests, a health plan, managed care organization, or mental health review agent that fails to timely act on a prior authorization request cannot then deny or recoup benefits for non-medically necessary care or treatment for services because the request was deemed to have been granted.

A "completed prior authorization request" is one that contains sufficient information such that a health plan, managed care organization, or mental health review agent is able to make a determination without requesting additional information. If a health plan, managed care organization, or mental health review agent determines that additional information is necessary to make a determination, it has 24 hours to request any missing information or the request is deemed to have been granted under 18 V.S.A. § 9418b(g)(4). Upon receipt of the missing information by a health plan, managed care organization, or mental health review agent, and assuming the receipt of the missing information renders the prior authorization request "complete," the statutory time frames contained in 18 V.S.A. § 9418b(g)(4) apply.

Scope of Bulletin and Filing Requirements

A health plan, managed care organization, or mental health review agent not currently in compliance with Vermont law as described in this Bulletin must come into compliance. A health plan, managed care organization, or mental health review agent not currently in compliance that has already filed its policy form with the Department is not required to amend its policy form or seek an approved rider, but must still comply with Section 5a of Act 79 of 2013. A health plan, managed care organization, or mental health review agent not currently in compliance that has not filed its policy form with the Department as of the date of this Bulletin must file a policy form that complies with Section 5a of Act 79 of 2013.

Enforcement

Failure to comply with Vermont law may be subject to enforcement pursuant to Titles 8 and 18.

Susan L. Donegan
Commissioner

Effective Date: July 15, 2013