



PARTNERS *in* CARE

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From the Desk of the Medical Director HPV and Vaccination

*By Dr. James A. Duncan
Medical Director, VMC*

The HPV vaccine is being widely proclaimed as a true cancer vaccine. I recently attended an excellent lecture by Dr. Martin Mahoney of the Roswell Park Cancer Institute and wanted to summarize some of his key points.



Virology

- Of the 130+ Human Papilloma Virus types, three distinct groups, mostly mutually exclusive, are involved in
 - (a) cutaneous warts,
 - (b) mucosal/genital warts, or
 - (c) cancers of the cervix and other mucosal tissue.
- There are 15 plus “high-risk” HPV types that are etiologic in virtually all cervical cancers, most anal cancers, half of penile/vaginal/vulvar cancers, and some oropharyngeal cancers.
- The “low-risk” types cause warts or benign low-grade cervical lesions.
- Types 16 and 18 account for 70% of cervical cancers.
- Types 6 and 11 account for over 90% of genital warts.

Epidemiology – HPV

- 20 million individuals are infected in the US (15% of those are ages, 15-49) (Some estimates in adolescent and young women as high as 80%)
- HPV infection rate increases with the number of lifetime partners (>50% infection rate with 4 or more partners)

Epidemiology – Cervical Cancer

- 10,000 new cases annually in the US (approximately 4,000 deaths annually)
- 50% of new cases occur in women who have never been screened.

Epidemiology – Sexual Activity

Age:	<u>< 13</u>	<u>15</u>	<u>17</u>	<u>19</u>
Vaginal intercourse:	7%	25%	50%	75%

Vaccine

There are currently 2 vaccines, both given in three doses:

- Gardasil – tetravalent against types 16, 18, 6, 11 (available)
- Cervarix – bivalent against types 16, 18 (pending approval) (Seroconversion > 99.5% after 3 doses of Gardasil)

ACIP recommendation:

- Routine for girls age 11-12 (can be given as young as 9)
- “Catch-up” for girls/women ages, 13-26

The vaccine is covered for all VMC contracted health plans (MVP, TVHP & FAP) when given for indicated use in accordance with the member’s benefit plan and policy provisions.

Issues

- 30% of cancers are NOT preventable with the vaccine (non-16/18 virus types), thus Pap screening is still needed.
- Is there a benefit for women older than 26?
- Possible future role for male vaccination for greater population immunity, and prevention of penile and anal cancers.
- 80% of cervical cancers occur in the developing world.



Provider Newsletter

PARTNERS *in* CARE

We encourage our readers to call or write us with your feedback about our newsletter.

Contact Martita Giard at

847-8161 or email to:

martita.giard@vtmednet.org

Partners in Care is provided as an informational and educational service for participating providers in Vermont Managed Care, Inc. To the extent the content concerns operations and programs of Vermont Managed Care, the terms of applicable contractual and other legal documents shall prevail. Program descriptions and other specific content are for use in connection with Vermont Managed Care programs and are not intended to direct or prescribe activities unrelated to Vermont Managed Care.

New Mandatory CMS 1500 Form and UB 04 Forms are on the way

By Elizabeth Roach, External Provider Relations Specialist

The CMS 1500 Claim Form was revised to accommodate the reporting of the National Provider Identifier (NPI) number. The NPI will be a single provider identifier, replacing the different provider identifiers health care systems currently use for each health plan with which you do business.

Because of the number and types of changes the new CMS 1500 includes, you will most likely need to update your billing software programs to reflect these changes. Now is the time to update your billing system software to ensure your office is ready for the April 2, 2007 deadline. To ensure your billing system is able to accommodate these changes, it is best to talk with your software vendor or clearinghouse as soon as possible.

CMS has stated that the new 1500 form implementation will be effective January 1, 2007, and the form will be available on January 1, 2007. However, you won't be required to use the new form until April 2, 2007. During the transition period, BCBSVT will accept the old 1500 form only: the revised CMS 1500 will not be accepted until required on 4/2/07. MVP and Apex will accept both the current and revised forms. Meaning you can use either the new version (08-05) or the current version (12-91) as follows:

January 2 – March 30: you can use either the current form or the revised CMS 1500 form (08-05). Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised CMS 1500.

After April 2, you will only be allowed to use the new CMS 1500 form. This will include any resubmission of claims you need to handle after April 2, 2007, regardless of the date of service.

For a list of changes from the current CMS 1500 to the revised CMS 1500, you can view the change log document posted at www.nucc.org (National Uniform Claim Committee).

The UB-92 will be replaced with the UB-04 effective May 23, 2007.

The UB-04 contains a number of improvements that resulted from nearly four years of research; improvements include better alignment with HIPAA standard transactions for institutional electronic billing, transition to NPI, anticipated migration from ICD-9 to ICD-10, greater flexibility for public health reporting.

March 1 – May 23: you can use either the current form or the revised UB-04 form. Please contact each health plan, clearinghouse and/or vendor you do business with directly to confirm whether or not they will be ready to accept and use the revised UB 04.

The new UB-04 form will be required for use effective May 23, 2007: this includes any new or resubmitted claims, regardless of the date of service.

For additional information regarding the UB-04 please visit www.nubc.org.

VMCs Low Utilization Counters Industry Trends

By Cliff Frank, President Vermont Managed Care

For the last 30 months, VMC's inpatient admission rate has been consistently less than our target; this is especially remarkable given that our target of 55 admissions per 1000 is 15% lower than national goals. Interestingly, the hospitalization rate for VMC members was below that of other payers in our service area. Six or even twelve month dips and surges in admissions might be expected, but this extraordinary continuous low utilization for 2½ years makes a simple cyclical lull unlikely.

Why has our experience been so favorable, and is it sustainable? There are certainly multiple reasons, at least

some of which are cause for optimism.

We believe that VMC physicians adhere to clinically appropriate use of hospital services, which is reflected in the fact that our use rates for most facility-based services compare favorably to national and regional benchmarks.

VMC's care management team gets involved with patients suffering from serious illnesses as early as possible. Our care managers work closely with those patients and VMC providers to ensure that care is directed toward early detection and intervention, with the goals of preventing further complications or a decline in health. These collaborative efforts may certainly help to

avoid some admissions. For those patients who do require hospitalization, our care managers stay involved, and participate in discharge planning, follow-up care and recovery services. This may help lower the rate of re-admission in this high-risk group.

VMC continues to strengthen our care management services, encouraging preventive health care, early detection and intervention, and identification and intervention for high-risk patients. This investment lowers costs and keeps members healthy, both of which make good sense for VMC patients and providers.

2006 VMC Board Retreat

By Cliff Frank, President Vermont Managed Care

The VMC Board of Directors met on the evening of November 9, 2006, to review our progress to date since the last retreat, and to set direction for the coming years. VMC is successful in managing the patient population for which we are at risk but that population has been declining as employers migrate from HMO to PPO insurance plans and from fully insured to self-insured products.

After assessing VMC's strengths and prospects for the future the Board identified that several initiatives should be key drivers of our future success and to continue to achieve positive results.

The initiatives include:

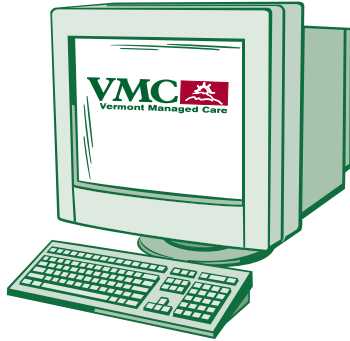
- 1) Evaluate methods of rewarding superior clinical performance.
- 2) Expand VMC services to encompass additional populations where VMC might add value in the clinical review process.
 - a) The State of Vermont is looking at new initiatives in care management for Medicaid and under-insured populations. VMC should bid on those proposals where our care management services would be paid for by the State on a fee-for-service or fee-per hour basis.
 - b) Evaluate opportunities in Medicare Demonstration grants and other non-traditional care management opportunities.

- 3) Decline to reduce VMC fee schedule for MVP ASO (self-insured) product recognizing that MVP will need to contract directly with VMC providers for that product.

The Board also concluded that VMC will continue to enhance our care management capabilities without undue intrusion on physician practices and to continue to seek to expand our attractiveness to payers in our market region. As a provider organization, we welcome the thoughts and ideas of our providers on these new initiatives. Please contact Martita Giard at 802-847-8065 or toll free at 800-639-3881 or by email at martita.giard@vtmednet.org to share your thoughts.

Spotlight on the VMC Web Site

By Kevin W. O'Neal,
External Provider Relations
Specialist



The VMC Provider Manual, updated for 2007, is now available on the VMC Web Site at www.vermontmanagedcare.org/Providers/provider_manual.html. The annual update continues to bring practice management information you need to know about into one location. The VMC Provider Manual is referenced in your VMC Participating Provider Agreement as your resource for VMC policies, plans, and logistical information. Information on VMC, Payer requirements, and State and National legislative summaries can all be found in the manual.

Updates include

- Board of Directors listing
- Credentialing and Care Management Plans
- VMC Policies
- Revised “Matrices” in Section 4 reflecting 2007 payer requirements
- Sections 5, 6, and 7 include the most up to date payer forms and information

Since many practices and hospitals have web access, we are making the VMC Provider Manual available on our website. However, if your office is unable to conveniently access the VMC Provider Manual via our web site, please give VMC Provider Relations a call at 802-847- 6253 or toll free at 800-639-3881 and we will gladly provide you a copy on CD. The VMC Web Site can be found at www.vermontmanagedcare.org.

NPI Update

By Martita I. Giard, Director of Network Development & Provider Relations

VMC continues to receive your NPI numbers, but we still need to hear from many of you. Below is an overview of our receipt rate as of December 11th.

# NPI's expected:	2,731
# NPI's received:	762
# NPI's to be received:	1,969
% Complete:	28%

Although May 23, 2007 is still four months out, the health plans need time to key in all of these numbers and test their systems. If you have not forwarded your NPI to VMC, please do so as soon as possible. We will relay this information to MVP, TVHP/BCBSVT, and APEX for the Fletcher Allen Preferred Medical Plans.

How Do I Send NPI Information to VMC?

Your NPI can be sent to VMC in any of the following ways:

- 1) If there are multiple providers in your practice, you can send the information in an excel spreadsheet. Please include the following fields.
 - First Name
 - Last Name
 - Degree (MD, DMD, etc.)
 - Practice Name
 - NPI
- 2) Send or fax VMC the confirmation page you received from CMS; or
- 3) Call VMC

How to Reach VMC:

- Email: vmcproviderenrollment@vtmednet.org
- Fax: 802-847-3427 – Attn: Credentialing Department
- US Mail: PO Box 1150
Burlington, VT 05402-1150
Attn: Credentialing Department
- Phone: 802-847-8161

When will MVP, TVHP/BCBSVT and APEX be able to accept the NPI on electronic claims?

	Can Accept NPI As Of:	Must I Submit My NPI and My Payer Specific Provider ID Number?
APEX	10/2/06	YES
MVP	12/1/06	Yes from 12/1/06 to 5/22/07*
TVHP / BCBSVT	Right Now	05/23/07 or will notify if sooner
*This is the recommended approach but is not mandatory.		

Events & Notices

Provider Practice and Billing Changes, Additions or Terminations

By Martita I. Giard, Director of Network Development & Provider Relations

VMC is responsible for notifying MVP, TVHP and APEX (the third party administrator for the FAP plans) of any change in a provider's profile. It is imperative that VMC receive written notification of these changes 60 days in advance as outlined in Section 2.10 of your Participating Provider Agreement with VMC. Examples of changes which VMC must receive in writing include, but are not limited to.

- Adding a new provider
- Terminating a departing provider
- Changing the practice name, address, phone number, billing name, billing address or tax identification number
- Opening or closing the practice to new patients

VMC will need a copy of the W-9 Form "Request for Taxpayer Identification Number and Certification".

- Before a new provider can be enrolled
- Adding a new location for an existing provider
- Changes in billing name or change in business name
- Taxpayer Identification Number changes.

Modifications to a contracted VMC provider's practice will become effective no later than 60 days from the date VMC receives written notification.

While we have historically shortened this timeline whenever possible, the volume of provider changes we receive are limiting our ability to flex this as much as we would like to. Keep in mind, once VMC processes the information, the Health Plans/TPA (MVP, TVHP, APEX) then have to process and implement the change. Please send changes to VMC, attention Network Profile Specialists. Changes may be sent by fax to 847-6214 or by email to VMCProviderEnrollment@vtmednet.org

VMC Participating Provider Agreements

By Gretchen Begnoche, Senior Contract Specialist

Vermont Managed Care has a policy that we will conduct a legal review of the Participating Provider Agreements every 5 years, or after 5 Amendments, for compliance with laws and other changes to maintain their accuracy and efficacy. During 2007 you may expect to receive an Amended and Restated Participating Provider Agreement that will incorporate various Amendments to your current Agreement that you have received over the past several years and other necessary changes to ensure compliance with state and regulatory requirements.

Direct EDI with Apex

By Kevin O'Neal, External Provider Relations Specialist

VMC is pleased to announce that Apex Benefits Services, VMC's third party administrator for the Fletcher Allen Preferred Medical plans, will now be able to accommodate direct Electronic Data Interchange (EDI). Providers may begin billing directly to Apex, without the need for a clearing-house intermediary. HIPAA standard transactions 837 (claims) and 835 (Remittance Advice) directly between the provider office and Apex are available for immediate use. If your office is interested in billing Apex directly, please contact your VMC Provider Relations Representative Kevin O'Neal at 847-8358 or Elizabeth Roach at 847-4035. Applicable forms and contracts will be faxed to you upon your request.

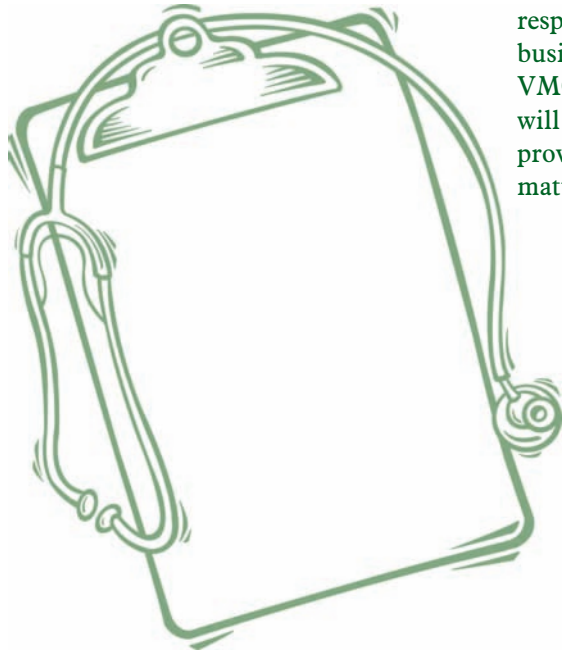
Overpayment Policy for Fletcher Allen Preferred Medical Plan (FAP)

By Elizabeth Roach, External Provider Relations Specialist, & Shawntel Burke, Supervisor Managed Care Services

The Fletcher Allen Preferred Medical Plan refund policy and the process for overpayments and refunds are identified below.

Policy: To ensure that controls are in place to identify and correct overpayments in the Third Party Administrator (APEX) claims system and to ensure that refunds are collected in a timely manner.

Purpose: To credit the FAP Medical Expense Account for any claim overpayments and to maintain the integrity of the paid claim files, regardless of reason for refund.



Refunds

Refund requests may be generated by a VMC provider, FAP member (ex. A member may pay for services up front then submit the claim to APEX for processing) or by APEX for the Fletcher Allen Preferred Medical Plans. If an overpayment is identified by VMC or APEX an overpayment letter will be generated and sent to the provider's office. If the refund has not been received by VMC within forty-five (45) days from the date of the original request, a second Request for Refund letter will be sent. If after fifteen (15) days there is still no response to the Request for Refund letters, a VMC Customer Service Representative will contact the billing office or office manager. If VMC has not received a response/refund within ten (10) business days of the phone call, your VMC Provider Relations Representative will contact the billing office or the provider personally to resolve this matter.

Overpayments

If your office identifies an overpayment for Fletcher Allen Preferred Medical Plan member, please forward the original check to VMC for processing if you have not deposited the payment. If you have processed the payment, then please submit a check in the amount of the overpayment to VMC, Attn: Shawntel Burke.

If VMC identifies an overpayment, the refund notification process will occur within one hundred twenty (120) days from the last date of adjudication. Overpayments identified by provider offices will need to be refunded to VMC within one hundred twenty (120) days from the last date of adjudication.

All refund and overpayment issues are managed through the Vermont Managed Care office. For further information or assistance please contact Shawntel Burke, Supervisor, VMC Customer Service at 847-8495 or toll free at 866-582-6836.

Fletcher Allen Medical Plans Outcome Measures

By Shawntel Burke, Supervisor Managed Care Services

VMC continues to regularly monitor performance measures to ensure high quality service to our members and providers. The following is a synopsis of selected performance measures for the time frame of January – November 2006. If there are ways we can serve you better please let us know.

January – November 2006	Goal	VMC Performance
Customer Service		
Average time to answer Calls	45 Seconds	18 Seconds
Abandoned Call Rate	less than 3 %	1.3%
Time on Hold	less than 45 seconds	23 Seconds

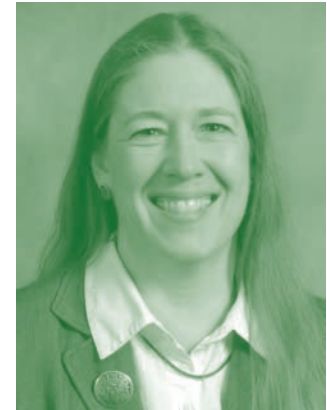
Claims Processing	January – November 2006	
Clean Claim Turnaround		
1-14 days	75%	83.5%
15-30 days	93%	95.2%
31-60 days	99%	99.8%
Claims Payment Accuracy	98.5%	97.9%



VMC Employee Spotlight

Senior Contract Specialist

By Elizabeth Roach, External Provider Relations Specialist



Vermont Managed Care welcomes Gretchen Begnoche, Senior Contract Specialist, to our team. Gretchen recently transferred to VMC from Fletcher Allen Health Care's Contracting Department, where she had worked for the past twelve years as a Contract Analyst. Her principal responsibilities were negotiating and contracting with insurance companies for health care services provided by FAHC.

Since 1994, Gretchen also provided integral support to the Payer Contracting efforts of VMC as a contributing participant in developing the payer contracting process for VMC, including contract strategy and the development and maintenance of sound Agreements with our Payors on behalf of our Network.

In addition to payer contracting, Gretchen will hold responsibilities in the areas of compliance, HIPAA, legal affairs, and clarifying and documenting internal policies and procedures.

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Family Practice

Paul Unger, MD
Vermont Center for Cancer
Medicine, Inc.
Hematology/Oncology

Dennis Vane, MD
Fletcher Allen Health Care
Pediatric Surgery

* Board Officers

Vermont Managed Care Contact Numbers



Phone #	Phone # FAP	Fax #
Main		
802-847-8161		802-847-6214

Customer Service (CS) / Case Managers (CM)		
802-847-8369 (CS)	802-847-4862 (CS)	802-847-6213 (CS)
800-639-3881 (CS &CM)	866-582-6836 (CM)	802-847-6212 (CM)

Provider Enrollment (PE) / Provider Relations (PR)		
802-847-8161 or		802-847-3427 (PE)
800-639-3881		802-847-6214 (PR)

A complete phone list of all staff is available in the VMC Provider Manual available online at www.vermontmanagedcare.org.

Tel. (802) 847-8161
(800) 639-3881

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