

March 2003

Vermont Managed Care

Provider Newsletter



PARTNERS *in* CARE

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

Contact Roberta Mitchell
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A Day in the Life of the Medical Director

*By Dr. James A. Duncan
Medical Director*



Several recent conversations have made me realize that most providers have only a vague understanding of the job of the VMC Medical Director, so I thought I'd take this opportunity to "flesh out" the role for you.

Care management is the core responsibility. The medical director reviews requests for services which (1) don't meet standard screening criteria for medical necessity (2) would require an exception to the insurer's benefit plan (3) are planned for an out-of-network provider, or (4) trigger any one of a number of other screens (certain drugs, equipment over \$500, home care services, etc.). Of course, each insurance plan has different review criteria, benefit limits, etc. which must be applied. Arriving at a decision may require talking to the member, the referring MD, the specialist MD, a separate specialist consultant, and the insurer, researching the medical literature including evaluation sources such as Hayes or Cochrane, and

sometimes requesting an outside agency expert review. Overall, about 80% of these reviews result in approval of the service; sometimes the service is modified or limited, sometimes a more timely or more appropriate service is arranged, sometimes care is redirected to an in-network provider.

If a member or provider appeals a denial, any additional information is examined and the case is looked at by the health plan's (e.g. TVHP, MVP) medical director, who makes an independent decision. The VMC Medical Director also serves on appeals committees for cases from other PHOs.

The Medical Director participates in the care management and quality improvement initiatives for VMC, MVP, TVHP and FAP,

continued on page 2

VMC Announces a New Associate Medical Director



Vermont Managed Care, Inc. is pleased to announce that Michael Burfoot, BM,BCh, FRCP(C) joined VMC as Associate Medical Director in December 2002. Dr. Michael Burfoot graduated from Oxford University in

Medicine in 1958 and started training in Surgery. During his first year he met a visiting American resident in Anesthesia and was intrigued enough to switch to training in Anesthesia himself. In 1963 he came to

McGill University for a year as a research fellow in Epidural Anesthesia. The social freedom of North America, the attractiveness of nearby Vermont and the professional opportunities made the decision easy for his family to not take the plane back at the end of the year. In 1978 an opportunity to join the anesthesia faculty at the University of Vermont arose and was eagerly accepted. Now, in stepping down from clinical practice somewhat, he has joined Vermont Managed Care as Associate Medical Director.

Dr. Burfoot may be reached at VMC at 847-8161 or by mail at PO Box 1150, Burlington, VT 05402-1150.

attending about 80 regularly scheduled meetings a year, as well as numerous other “add-ons”.

Corporate responsibilities include: participation in provider credentialing for VMC, TVHP and MVP; VMC finance, operations and strategic planning; development of clinical policies; assisting providers with reimbursement issues; and provider feedback on clinical and managed care policies.

Overall, the job is challenging but extremely rewarding. I have the opportunity to learn about the most current ideas and technologies, sometimes in discussion with the very people who are developing or implementing them. I am forced to ask the most basic question in medicine, “Does this work?”, often being surprised at the answer, or dismayed at the lack of an answer. And, of course, I get to learn from my colleagues about medicine, their patients, their practice and their perspectives on the practice of medicine in our community.

Provider Practice and Billing Changes W-9's

As detailed in the December 2002 newsletter VMC requests written notification of any change in a provider's profile information 60 days in advance of the effective date. VMC **also needs** a copy of the original W-9 Form “Request for Taxpayer Identification Number and Certification” before a new provider can be enrolled, for adding a new location for an existing provider, and for group billing name changes and/or TIN changes.

Total Joint Care Management Program and Home Care Pathway

VMC and MVP Nurse Care Managers have been working collaboratively to implement a care management program for members having total joint replacement surgery. The program is focused on providing a smooth transition from hospital to home care. A home care pathway has been developed that includes the following components.

- One in home pre-surgical evaluation of home support services, adaptive equipment needs and pain management by a participating home health agency Physical Therapist.
- A VMC Care Manager will be assigned to follow the patient's progress from pre-admission, through the hospital stay and post discharge to assure a smooth transition to the home care pathway.
- Upon discharge, a skilled nursing evaluation will be done at home to assess incisional healing, pain and medication management and physical assessment based on the discharge instructions.
- Following hospitalization, the patient will receive five physical therapy visits, with additional visits as needed.
- Attending physicians will be supplied with outcome reports on their patients.

The care management program includes notification to the attending physician that the patient has been identified as a potential candidate for the program and a request for physician approval. The member will be asked for consent to be enrolled in a care management program.

Improvements in discharge planning, speed of recovery from surgery, decreased hospital-related complications and improved patient satisfaction are anticipated as a result of this program. For more information on the program, please contact the VMC Care Management department at 847-8369. Details of the program will be provided through a direct mailing to the VMC orthopedic surgeons.

MVP and TVHP Late Referrals

MVP and TVHP have asked for assistance from VMC in reducing the number of late referrals that are being generated by our primary care providers (PCP's). A “late referral” is defined as a referral written after the patient has received the specialty or out-of-network care. When a late referral is received, VMC Customer Service is telephoning the PCP office and asking each patient's chart be reviewed to determine if the visit was authorized prior to the date the visit occurred. If the visit was authorized a note is put on the referral form indicating “office error”. If the visit was not authorized the referral is subject to Medical Director review and potential denial. This process causes additional work for both the PCP office staff and VMC.

VMC, in conjunction with MVP and TVHP, encourages PCPs to inform their patients that they will not generate referrals after the specialty visit occurs. VMC understands there will be instances when the PCP will determine a late referral is clinically appropriate. If you find you need to generate a late referral please indicate in detail the reason it is late on the referral form. VMC can then make a determination without contacting your office.

For your convenience, we have included a flyer in this newsletter that can be posted in your office and shared with your MVP and TVHP managed care patients. Please direct any questions to your VMC Provider Relations Representative.

VMC Fee Schedule

VMC completed a mailing in February to all providers notifying them of the VMC Professional Fee Schedule reimbursement changes that took place on April 1, 2003. These changes apply to the MVP, TVHP and Fletcher Allen Preferred Medical Plans. If you did not receive this mailing and would like a copy of the fee schedule and/or a copy of the mailing please contact the Provider Relations department at 847-8161. Please find the summary of the reimbursement changes listed below.

VMC Reimbursement Changes for CY 2003 (4/1/03-12/31/03) Summary

Professional Fee Schedule

1. Raised Floor to 130% of Medicare '02
2. Capped Ceiling at 215% of Medicare '02

3. Froze codes between 180 and 214% of Medicare '02 at same percentage of Medicare '01 if Medicare '02 decreased, and no change to code reimbursement where Medicare '02 increased (E&M codes were excluded)
4. Decreased E&M codes above 130% of Medicare '02 to 130% of Medicare '02
5. No change to most of the Laboratory, Radiology, Physical Therapy, Occupational Therapy, specialty dermatology codes
6. Raised codes greater than 130% and less than 150% of Medicare '02 by 5% (codes not included in 1-5 above)
7. Raised high volume/high discount codes to 150% of Medicare '02
8. Raised codes for high discount specialties to 150% of Medicare '02
9. Clinically reviewed and modified 57 codes after steps 1-8 were completed

Other reimbursement changes

1. Drug (non-prescription) fees are 100% of AWP October 2002 pricing.
2. DME fees are 115% of the Medicare DME POS fee schedule for Vermont for MVP and TVHP and 118% of FAP.
3. Change to the FAHC inpatient DRG base rate reflecting changes in the outlier provision, re-admission policy, and DRG weights. This change is effective 3/1/03 for TVHP and 4/1/03 for MVP and FAP Plans.

No changes were made to the following

1. Anesthesia conversion factor. This still remains at \$40.00 for MVP HMO, TVHP and FAP and \$45.20 for MVP SelectCare ASO.
2. Facility Discount Rates remain at 20% for claims not subject to DRG.
3. Care Management Fee paid to PCPs (\$2.50 PMPM) for MVP HMO and TVHP members.
4. Withhold remains at 15%.

VMC Board Initiates Strategic Planning Effort

By Clifford R. Frank, President



On February 11, 2003 the VMC Board met for six hours to begin the process of long range planning for VMC's future. Now that VMC's financial position has stabilized, the

VMC Board wants to re-examine VMC's role in the community and how we can have added value for physicians, hospitals, patients and employers. The Board considered regional and local trends in the health insurance market along with VMC's utilization and cost trends.

Rising healthcare costs remain a long-term threat to employers' ability to offer health insurance to their employees. VMC's important contribution to the community is to continue to provide physician leadership in decision-making

about enhancing medical care quality through reducing clinical utilization variation within particular diagnoses where feasible and clinically appropriate.

The VMC Board recognized that we have several advantages in addressing utilization trends that other networks in larger communities do not. First, the population for whom the physicians provide care is a stable one that will continue to receive our care for many years. Therefore, investment in early intervention and care for patients with chronic diseases is likely to generate long-term cost savings for the VMC network. Second, we have many physicians in the VMC network who still like to collaborate with their colleagues on issues of patient care. For example, every time VMC has held discussions with clinicians about clinical guidelines for use of certain procedures, we have

had excellent involvement from the affected specialties. Such willingness by VMC physicians to stay involved gives the organization a good start on developing new ways to address clinical utilization variations.

VMC staff was tasked with bringing back to the VMC Finance and Care Management Committees information that quantifies the scope of clinical utilization variation among high cost, high frequency, high variation diagnoses. In addition, VMC will be developing a plan to invite primary care and specialty physicians to participate in effective discussions about how to reduce unnecessary variations within particular diagnoses. We expect that this will be a multi-year, multi-specialty, multi-facility plan that will involve many physicians from various disciplines.

Fletcher Allen Preferred &

Fletcher Allen Medical Plans To Implement CodeReview

VMC contracts with Employers Mutual, Inc (EMI) of Jacksonville, Florida to process the claims for the Fletcher Allen Medical Plans. It has always been our practice to employ the latest in proven computer technology to process your claims in a timely and efficient manner. We are pleased to announce CodeReview will be implemented in the near future.

CodeReview is a system that uses a clinical knowledge base to detect, correct and document coding inaccuracies on CPT-4/HCPCS-coded claims. It provides consistent and objective claim review by accurately applying coding criteria for all clinical areas of medicine, surgery, laboratory, pathology, radiology, and anesthesiology. CodeReview assists the claims processor in evaluating the accuracy of submitted CPT-4/HCPCS codes. By “thinking” the way a physician-reviewer would, CodeReview uses a clinical knowledge base that results in medically based recommendations to the claims processor.

CodeReview assists the claims processor in evaluating the accuracy of the coding of the procedure(s), not the medical necessity of the procedure(s). It will help us to continue to reinforce existing coding practice standards as it is based upon the American Medical Association’s Physician’s Current Procedural Terminology, Fourth Edition (AMA CPT-4) guidelines as well as Health Care Financing Administration’s Common Procedure Standards (HCPCS) guidelines.

By implementing CodeReview we are ensuring claims are processed accurately and consistently and that we are in line with our other payers in the methodology used to process claims.

Fletcher Allen Preferred Outcome Measures

VMC began administering the Fletcher Allen Preferred Medical Plan in January of 2002. VMC regularly monitors performance measures to assure high quality service to our providers. The following is a synopsis of selected performance measures for the time frame of January-December 2002. If there are ways we can serve you better please let us know.

January-December 2002	Goal	VMC Performance
Customer Service		
Seconds to answer phone calls in member services	45 seconds	38 seconds
Time on hold	less than 45 seconds	43.3 seconds
Abandoned call rate	less than 5%	4.6 %
Claims processing		
Claim inventory backlog	less than 10 days	3 days
Claim accuracy	98.5%	Financial 99.81% Payment 98.37% Processing 97.56%
Claim payment cycle time	95% clean claims Paid in 20 days	12 days
Care Management		
Care Management decision time	within 48 hours	28.8 hours
Appeal decision time	within 15 days	1.8 days
Clinical documentation	95%	99%
Inter-rater reliability	90%	100%

FAP Maternity Wellness Program

On January 1, 2003 VMC began offering a maternity wellness program for Fletcher Allen Preferred and Preferred Plus members. The program offers pregnant members a choice of educational resources including the What to Expect When You’re Expecting series and coverage for childbirth education courses.



Available courses include preparing for childbirth, child/infant CPR and first aid and lactation support. VMC conducts a brief Health Risk Appraisal and provides high risk case management services. Members may voluntarily enroll in the program by contacting Jeanette Robinson, RN, CCM at 847-0606 or 866-582-6836.

Preferred Plus Plans (FAP)

Fletcher Allen Preferred Medical Plan Satisfaction Survey Results

In the fall of 2002 VMC conducted a member satisfaction survey for the Fletcher Allen Health Care employees covered by the Fletcher Allen Preferred Medical Plans. The survey was sent to members of each of the four plans, active employees and retirees. Surveys were sent by mail one per subscriber. The rate of response was 12% with 545 surveys returned of approximately 4,050.

Highlights of the results are listed below.

Overall Satisfaction with VMC administered FAP in 2002 compared with previous coverage in 2001

56% reported better or much better
12% neither better nor worse
4% worse or much worse
28% had no experience with the previous plan

Satisfaction with the FAP open access plan vs. a referral based plan

76% better or much better
33% neutral
1% worse or much worse

Satisfaction with Provider seen most often

92% satisfied or very satisfied
5% dissatisfied or very dissatisfied
3% neutral

Satisfaction with timeliness of appointment

83% satisfied or very satisfied
9% dissatisfied or very dissatisfied
8% neutral

Satisfaction with VMC Care Management Staff

68% satisfied or very satisfied
17% dissatisfied or very dissatisfied
15% neutral

Satisfaction with Customer Service

89% satisfied or very satisfied
2% dissatisfied or very dissatisfied
9% neutral

Professionalism of person answering the phone

95% satisfied or very satisfied
1% dissatisfied or very dissatisfied
4% neutral

Satisfaction with complaint resolution

84% satisfied or very satisfied
8% dissatisfied or very dissatisfied
8% neutral

In-network Hospitals

The following is a listing of in-network hospitals for the Fletcher Allen Preferred and Preferred Plus Medical Plans.

Central Vermont Medical Center
Berlin, VT

Copley Hospital
Morrisville, VT

Dartmouth-Hitchcock Medical Center
Lebanon, NH

Fletcher Allen Health Care
Burlington, VT

Gifford Medical Center
Randolph, VT

Mount Ascutney Hospital and Health Center
Windsor, VT

North Country Health System
Newport, VT

Northwestern Medical Center
St. Albans, VT

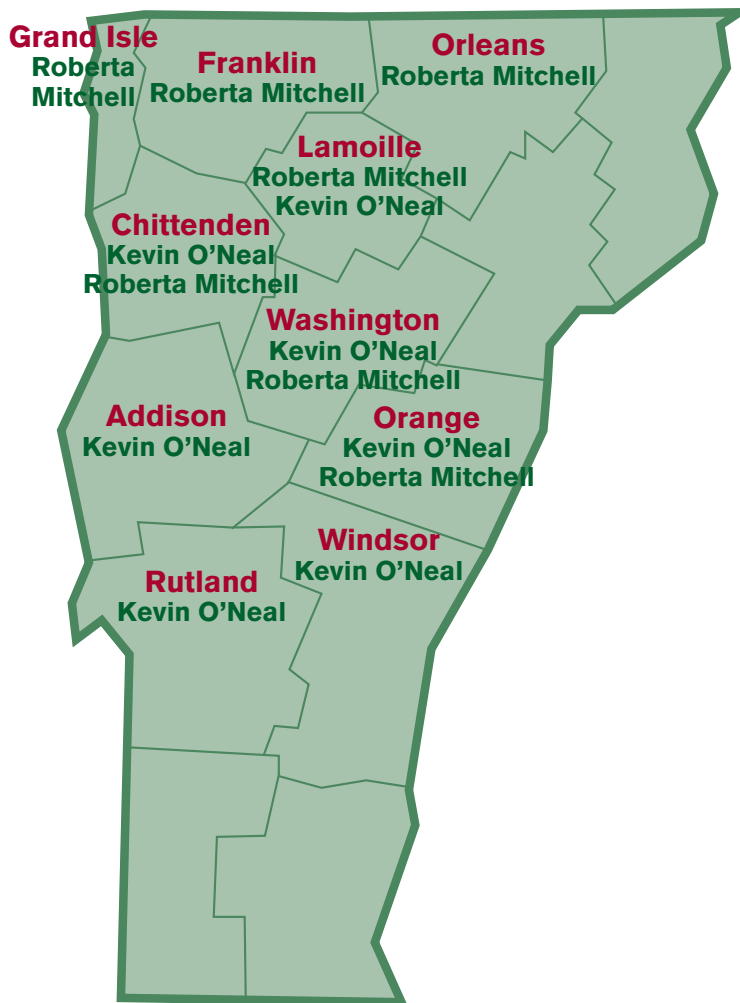
Porter Hospital
Middlebury, VT

Upper Connecticut Valley Hospital
Colebrook, NH

Weeks Medical Center
Lancaster, NH

Provider Relations Territories

There are two Provider Relations Representatives available to help you. Kevin O'Neal may be contacted at 847-8358 and Roberta Mitchell may be contacted at 847-2528. The map below indicates who your assigned representative is by county. In some counties one representative is assigned and in other counties Kevin and Roberta have assigned the provider offices located in the county. Please call Tiffani Filien in VMC Provider Relations at 847-8052 for confirmation of your representative. Clinton County, New York (not shown on the map) is assigned to Roberta Mitchell.



Clinton County, NY
Roberta Mitchell

VMC Care Coordinator's Geographic Assignments

All assignments are based on geographic location of patients Primary Care Physician (PCP)

Amy Bannister, R.N., CCM

Call (802)-847-6255 or page @ 802-847-1000 X 9660

Brandon, Bristol, Charlotte, Essex Peds, Hinesburg, Middlebury, Shelburne, Vergennes

Edwina Bartley, R.N. , COHN-S/CM

Call (802)-847-8483

Alburg, Richford, Enosburg, South Hero, East Fairfield, St. Albans, Fairfax, Swanton

Kitty Emerson, R.N., CCM

Call (802)-847-1358 or page @ 802-847-1000 X 3641

Essex, except Pediatrics, Colchester, Williston, except Williston Pediatrics

Darlene Morgan, R.N., CCM, CRRN

Call (802)-847-6259 or page @ 802-847-1000 X 9233

All Rehab Cases, Rutland County, Dartmouth Service Area

Carol Palmer, R.N., CCM

Call (802)-847-8271, or page @ 802-847-1000 X 5669

Burlington, FAHC Children's Health Care Services - Williston Pediatrics, South Burlington, Winooski

Jeanette Robinson, R.N., CCM

Call (802)-847-0606 or page @ 802-847-1000 X 5679

Berlin, Morrisville, Cambridge, Newport, Hardwick, Stowe, Johnson, Milton

Geraldine Smith, R.N. , CCM

Call (802)-847-8062 or page @ 802-847-1000 X 5668

Permanent out of area (NY, Cobra)

Care Coordinator On-Call 24/7

VMC offers nurse reviewer availability 24 hours a day, 7 days a week. The nurse is available by pager on off-hours and week-ends by dialing 802-741-2918.

VMC Care Management Utilization Management

UM Availability

The Care Management Department is available to you 24 hours a day/7 days per week to assist with Utilization Management (UM) determinations. During normal business hours you can call us directly through our local or toll-free numbers listed below. On weekends, holidays and off-hours you can receive assistance by contacting the on-call Care Coordinator by pager. If a Medical Director is needed, the on-call nurse will coordinate this.

Local Number: (802) 847-8369
Toll-free number: (800) 639-3881
On-call Pager: (802) 741-2918

UM Criteria

Annually the Care Management Committee of the Board approves the utilization management criteria for use as guidelines and benchmarks to inform the Care Management process. The most current version of the following criteria were approved at the January 2003 Care Management Committee:

<u>Criteria</u>	<u>Area of application</u>
Interqual	Surgical and Special Procedures, Diagnostics and Imaging
Milliman and Robertson	Inpatient, Home Care, Case Management, Recovery Facility
Hayes	New technology

We also have an arrangement with CORE, a review firm, who we can access for external review and specialty input.

Providers may request a copy of the criteria used to make a Utilization Management decision by contacting the Care Management Department at the numbers listed above.

Medical Director Availability

When there is an adverse determination for one of your VMC members you may always access a VMC Medical Director to discuss the case. You can make arrangements to contact one of them by dialing the numbers listed above and request a Care Coordinator. They will work to schedule a convenient time for you to discuss the case with one of the Medical Directors.

No Incentives

The purpose of Utilization Management is to facilitate efficient safe and appropriate care that meets standards for quality. Because this is one of the guiding principles for Care Management at VMC the Care Management Committee of the Board has adopted a policy that prohibits the application of incentives for anyone involved in making UM decisions. This policy can be found in the Utilization Management Plan. In summary, the volume or type of adverse determinations or denials does not affect in any way incentives given to any person. This includes Medical Directors, Care Coordinators, Managed Care Service Representatives, Managers or anyone involved in Utilization Management decisions.

UM Policies

The Utilization Management Policies are provided to you in the VMC Provider Manual and on the VMC website. The policies have recently been reviewed and revised. The updated policies will be distributed with the next Provider Manual update.

VMC Web Site



The Vermont Managed Care Web Site is now LIVE and available at <http://www.vermontmanagedcare.org/> This site is meant for both providers and patients, so please encourage everyone to take a look around!

Topics and services available through the web site are listed below.

- Information on each of VMC's contracted health plans (FAP, MVP and TVHP) and links to their web sites.
- Information on each of VMC's contracted facilities with links to their web sites.
- Details on VMC Network Policies, Care Management Policies and Credentialing Plans.
- Helpful Practice Operational Tools
- In-Network Provider search capabilities
- Detailed information on VMC and its staff including quick links for contacting VMC staff and departments.
- State and Federal legislation and healthcare links

Please let us know your thoughts by using the email "quick link" function.



Vermont Managed Care
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VMC Board of Directors

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Vermont Managed Care Contact Numbers



Phone #	Fax #	Phone # FAP	Fax # FAP
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Main*

847-8161	847-6214		
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Care Coordinators

847-8369	847-6212	847-4862	847-6212
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Customer Service

847-8369	847-6213	847-4862	847-6213
800-639-3881		866-582-6836	

*Provider Relations, Network Development, Data Management and Financial Operations may all be contacted through the main line. A complete phone list of all staff is available in your VMC Provider Manual.

Notice To Our Primary Care Patients

If your health plan requires referrals

- **Referrals MUST be requested in advance of your specialty visit.**
- **Referrals will not be written after the service has occurred.**

Thank you

Provided by



Notice To Our Specialty Care Patients

If your health plan requires referrals

- **You are responsible for requesting referrals from your Primary Care Provider BEFORE seeking specialty care.**
- **You may be financially responsible for some or all of the visit depending on your insurance coverage.**

Thank you

Provided by

