



PARTNERS *in* CARE

Vermont Managed Care
 P.O. Box 1150
 Burlington, VT 05402-1150
 Tel. (802) 847-8161
 (800) 639-3881

Clifford R. Frank
President

Barbara H. Drapola, RN,
 CCM, CPHQ
*Director of Operations &
 Clinical Affairs*

James A. Duncan, MD
Medical Director

Susan P. Shane, MD
Associate Medical Director

Thomas C. Dettre, CPA
Director of Finance

Martita I. Giard
*Director of Network
 Development & Provider
 Relations*

Elizabeth Roach
*External Provider Relations
 Specialist
 Newsletter Editor*

Inside:

Medical Imaging and 1
 Radiation Risk
 Electronic Preventive Services
 Selector (ePSS) 2
 NPI Update) 2
 Introducing the Continuity of
 Care Document (CCD) . . 3
 VMC Reimbursement
 Schedule Update 2007 . . 3
 Events & Notices 4
 Provider Network Survey
 Results 5
 MVP Providers Can See
 Preferred Care Members. 6
 "MyCare" 6
 Out of Network Services . . 7
 Spotlight on the Web Site . 7

From the Desk of the Medical Director Medical Imaging and Radiation Risk

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

As an Emergency Physician for 28 years, I have ordered countless x-rays and CT scans, with my major concerns being primarily clinical indication, and secondarily costs. The issue of radiation exposure had always been a distant third, except in pregnancy. Recent studies have shed light on a level of potential risk which could change medical practice.



Exposure in mrem

(ICRP recommended maximal annual exposure limit is 100 mrem = 1 mSv)

Annual background exposure	300
Plain film: Chest (PA & lateral)	6
Lumbar Spine (AP and lateral)	100
IVP	250
Barium Enema	700
CT study:* Head	200
Abdomen	1000
Nuclear: Bone	440
Cardiac	800-1700
Procedural: PCTA	up to 5700

* CT accounts for 70% of medical x-ray radiation exposure

A Yale study shows: patients with 3 or more renal colic CTs had 2000 – 15,000 mrem dose (Japanese atom bomb survivors had 500 – 20,000 mrem exposure)

Risks

- The National Academy of Science reported that a 1000 mrem dose is associated with a 1 in 1000 lifetime risk of leukemia or solid cancer.
- For the same dose, the Nuclear Regulatory Commission estimates a 1 in 2500 chance of a fatal cancer.
- A Lancet article concluded that in Australia, 1.3 % of all cancers are due to medical imaging (3.2% in Japan).

- A Swedish cohort study of young children exposed to radiation for cutaneous hemangiomas showed a dose-dependent decline in cognitive function, and reduction in high school attendance by as much as 50%.
- Clearly, all such estimates depend on assumptions and methodology, but the bottom line is that there is a risk, and the risk may be substantial.

Perspective

Some clinical perspective can be given by the following:

Overall fatal cancer risk:	20%
Days of life lost from:	1000 mrem/yr age
18-65:	51 days
15% overweight:	2 years
smoking 1 pack/day:	6 years

Bottom Line

Cancers and fatalities from medical imaging are a small problem compared with such major issues as smoking and being overweight and the overall cancer incidence. However, this is one factor that we clinicians directly control, and we must recognize that there are patients whose cancers are directly attributable to radiation exposure ordered by a well-meaning provider. In the case where the need for a CT is not definitive, we can no longer say, "let's just do it, there's no downside."

Electronic Preventive Services Selector (ePSS)

By Elizabeth Roach, External Provider Relations Specialist

AHRQ's Electronic Preventive Services Selector (ePSS) is a quick, hands-on tool designed to help primary care clinicians identify and offer the screening, counseling, and preventive medication services that are appropriate for their patients. The ePSS is based on the current, evidence-based recommendations of the U.S. Preventive Services Task Force (USPSTF) and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors. Available both as a Web-based selector and as a downloadable PDA application, the ePSS brings the prevention information clinicians need such as recommendations, clinical considerations, and selected practice tools to the point of care.

Search Screen

On the "Search for Recommendations" screen, all fields are optional.

To access the Electronic Preventive Services Selector go to: <http://epss.ahrq.gov/ePSS/introduction.jsp>. Below is an example of the search screen.

Electronic Preventive Services Selector (ePSS) - Mozilla Firefox

U.S. Department of Health and Human Services

Search for Recommendations

Please enter the following information to retrieve recommendations from the USPSTF Preventive Services Database. All fields are optional.

1 Age: [] Years

2 Sex: [] Female [] Male

Pregnant: []

3 Tobacco User: [] Yes [] No

4 Sexually Active: [] Yes [] No

Reset Show Recommendations

U.S. Department of Health and Human Services

Agency for Healthcare Research and Quality

NPI Update

Elizabeth Roach, External Provider Relations Specialist

As you are aware, the HIPAA regulatory date for the National Provider Identifier was May 23, 2007. VMC has collected approximately 85% of our network provider NPI's. We would like to thank all those providers who have forwarded their NPI numbers to VMC. For those providers who have not yet obtained an NPI, please do so immediately and forward to VMC. We will relay your NPI number to MVP, TVHP/BCBSVT, and APEX. VMC is sending monthly NPI reports to these organizations and we will continue to do so until, all VMC network provider NPI's are received. Services rendered and submitted for reimbursement to Health Plans by Providers who have not yet obtained an NPI may be rejected.

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 Dept.
Phone: 802-847-8161

Apex has implemented a contingency plan until January 1, 2008 for electronic claim submissions. They will accept NPI only, legacy only, or both NPI and legacy values until January 1, 2008. On January 1, 2008, Apex will begin to reject claims that do not contain an NPI. Apex will accept paper claims with Legacy number only, NPI only, or both NPI and legacy values with no cut off date.

MVP is extending the CMS dual strategy approach adopted in 2006. Until further notice, providers and facilities should continue to submit both an

MVP provider ID (legacy) number and NPI number on all HIPAA covered transactions, including claims submitted electronically. The NPI number should appear in field 33A. The MVP provider ID (legacy) number should appear in field 33B. The field should include the G2 qualifier. Paper claims will be accepted with your MVP PID/Legacy number or NPI number only. MVP will pay the claim until such time that CMS changes the rule and requires only NPI on the claim

TVHP will require the NPI number only effective May 23, 2007 for Electronic HIPAA compliant 837 format unless you have filed a contingency plan with BCBSVT/TVHP. Contingency Plans should be submitted to Wendy York, Provider Relations, at yorkw@bcbsvt.com. Paper claims will be accepted with your proprietary BCB-SVT Provider/Vendor numbers or your NPI until 8/1/07. After 8/1/07 your NPI is required.

Introducing the Continuity of Care Document (CCD)

By Kevin O'Neil, External Provider Relations Specialist

The Continuity of Care Record (CCR) has been picking up support and steam throughout the healthcare community. And now, through the collaboration of two of the world's largest developers of electronic standards, the Continuity of Care Document (CCD) is poised to take over and realize the long awaited potential of clear and understandable electronic exchange of clinical information.

The CCR was developed in a joint effort by a consortium of multiple provider and patient sponsoring organizations. Those organizations include the Massachusetts Medical Society, American Academy of Family Physicians, American Medical Association, the Patient Safety Institute, and ASTM International (originally known as the American Society for Testing and Materials), a world leader in the development of information standards. The purpose of the CCR was to provide a document that presented a snapshot in time: a core data set of most relevant facts about a patient's health-care.

The CCR was to be organized and transportable, prepared by a practitioner at the end of a healthcare encounter, enable the next practitioner to readily access such information, and to be prepared, displayed and transmitted on paper or electronically. Since the document uses XML web-based language, it can easily be transported via secure web portals, or encrypted e-mail. The CCRs standardized Care Elements are:

- Document Identifying Information (date, purpose)
- Patient Identifying Information (demographics)

- Patient Insurance / Financial Information
- Advanced Directives
- Patient Health Status (Hx, Meds., Lab/Rad, warnings, risks, immunizations, etc.)
- Care Documentation (providers seen, recent visits, etc.)
- Care Plan Recommendations
- Provider (information on current providers)

In February 12, 2007, Health Level Seven (HL7), a leader in electronic health standards development, with the collaboration of ASTM International E31 Healthcare Informatics Committee announced that the CCD was approved by balloting and also endorsed by the Health Information Technology Standards Panel (HITSP). The CCD represents the marriage of the CCR with HL7's Clinical Document Architecture (CDA). According to HL7, the new CCD will be published soon and will describe how to implement.

Look for future articles on these exciting developments in future editions of the "Partners in Care Newsletter" or visit the VMC "EHR Resources" page in the "Providers" section of our web site at www.vermontmanagedcare.org/Providers/ehr_resources.html

VMC Reimbursement Schedule Update 2007 (MVP, TVHP, FAP)

By Nicole LeBlanc, Clinical Project Coordinator

In early January, copies of the VMC reimbursement schedule(s) and a letter explaining the methodology for this year's updates were sent by certified mail to each VMC provider group. VMC reimbursement changes went into effect January 1, 2007. Over the past several years VMC has been fortunate to provide consistent reimbursement increases to our network.

Recent billings and pricing inquiries by our network providers resulted in the need to price approximately 120 new codes including the Gardasil vaccine, new radiology codes for mammographies and several other codes. Throughout the year, new codes billed by network providers are added to the reimbursement schedules. These codes are subject to the methodologies VMC employs to price new codes, and to payers' implementation requirements. Billed codes that cannot be priced are paid at a percentage of billed charges. Effective July 1, 2007, VMC will implement a reimbursement schedule update. This update consists primarily of drug and vaccine updates, with minor changes/additions to other types of reimbursement.

If you require reimbursement information on any new codes please contact Provider Relations at 847-8161 or toll free at 800-639-3881.

Events & Notices

New Identification Cards Issued for Fletcher Allen Preferred Medical Plans

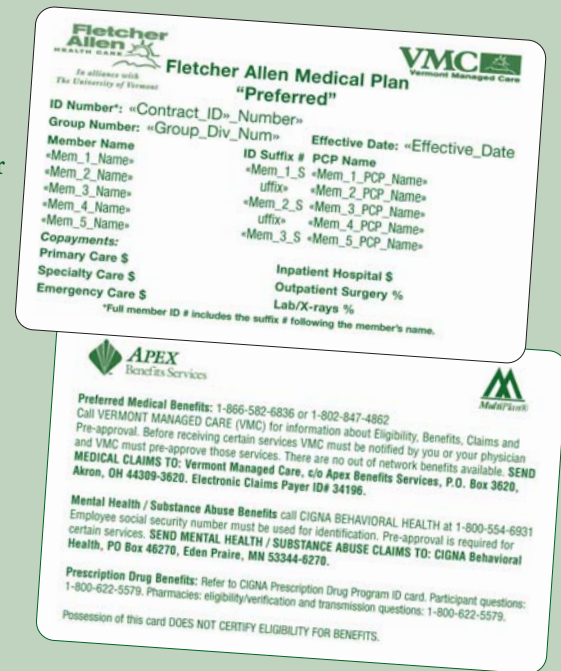
By Roberta L. Mitchell, Senior Account Representative

Subscribers of the Fletcher Allen Preferred Plan received redesigned Identification Cards in February 2007. The ID number and the group number have all remained the same.

The newly designed cards are reformatted to include as many as five family members on one card, eliminating the need for every member to have his/her own ID card. Please note – the full member ID is the suffix number following the member's name.

The back of the card has also been updated with a new phone number for the Prescription Drug Benefit (for the Preferred and Preferred Plus Plans). Contact information for Mental Health/Substance Abuse Benefits and Medical Claims Submission information remain on the back of the card as well.

The older version of the Identification Card is still valid as the ID and Groups Number have not changed.



Direct EDI with Apex

By Kevin O'Neil, 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 clearinghouse 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.

Expanded Services Now Available Through Apex Provider Portal

By Elizabeth Roach, External Provider Relations Specialist

Vermont Managed Care's third party administrator, Apex Benefits Services has transitioned its benefits, claims, eligibility and authorization tracking provider portal from Navimedix to Apex Plan Central. This transition took place on May 1, 2007.

Access to the provider portal is still available through the Apex Plan Central page by accessing any of the following:

- VMC website
www.vermontmanagedcare.org under important links. To access the login screens, click on the Plan Central link. After you successfully log in, the Provider Home page will display.
- www.apex-benefits.com/common/templates/plancentral.asp.
- Or on the SummaCare and Apex websites, www.summacare.com and www.apex-benefits.com

If you are not currently accessing this website and would like to please contact, Kevin O'Neal or Elizabeth Roach at 847-8161 or toll free at 800-639-3881.



CMS1500 Form Update

By Elizabeth Roach, External Provider Relations Specialist

It was brought to the attention of CMS that some of the new CMS 1500 (08-05) forms were incorrectly formatted. Versions of the revised form sold by print vendors, specifically the Government Printing Office (GPO) were formatted incorrectly.

CMS has extended the acceptance period of the CMS-1500 Form (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. Payers will be directed to continue to accept the CMS- 1500 Form (12-90) until notified by CMS to cease. At present, the target date is June 1, 2007. In the interim payers will be directed to return, not manually key, any CMS-1500 (08-05) forms received which are not printed to specification.

Please note that MVP will be accepting the new CMS 1500 (08-05) form. However, forms submitted which are incorrectly formatted, as indicated in the CMS form update, will be returned to the provider if they are identified as being the incorrect form at the time of receipt. TVHP and FAP are currently accepting the new CMS 1500 (08-05) form.

For additional information go to: <http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/1500FAQs.pdf>

It is important to note that this issue involves the implementation of the new Form CMS-1500 (08-05) only and does not impact the May 23, 2007 implementation date of the NPI.

Provider Network Survey Results

By Martita Giard, Director of Network Development & Provider Relations

Last Fall we sent you a survey specifically asking about our utilization management and provider relations functions at VMC. Although the return rate was very low (2.8%) we want to provide you with the results we did receive. We understand that you are being asked to participate in various surveys and we would like to thank those of you who did take the time to respond. Your feedback is appreciated and we welcome hearing from our network anytime.

Scale:

- 0 - Not Applicable
- 1 - Worse to deal with
- 2 - Ok but could use improvement
- 3 - Best to deal with
- 4 - Really Terrific

Utilization Management Questions: Average Ranking

- | | |
|---|-----|
| 1. How easily is it to speak to a nurse case manager when you need to? | 3.3 |
| 2. How quickly are your pre-approval requests handled? | 3.1 |
| 3. Are you able to speak to a Medical Director as needed? | 2.8 |
| 4. Have you been able to reach someone off-hours or weekends for a decision? | 2.9 |
| 5. Have your issues been handled to your complete satisfaction? | 3.0 |
| 6. If one of your patients was under case management, how satisfied were you with the care they received? | 3.0 |

Provider Relations Questions:

- | | |
|--|-----|
| 1. When you call your PR Rep, is your question handled in a timely manner? | 3.3 |
| 2. When a PR Rep visits your office, do you find the material covered to be relevant to your business? | 3.3 |
| 3. Do you see VMC PR as your advocate for issue resolution with our contracted payers? | 3.0 |
| 4. When using the VMC web site as a resource tool, can you find the answers you need? | 3.0 |

MVP Providers Can See Preferred Care Members

Written By: MVP

Starting on January 1, 2007, members of MVP and Preferred Care can be treated by participating providers of either health plan. This is the first step since the merger in January of 2006 to integrate the two provider networks, including hospitals and ancillary practitioners, into one network that can treat members from both plans. Below are key points to assist you in providing care to Preferred Care members:

- The frequency of Preferred Care members seeking treatment in MVP service areas should be minimal. Neither MVP nor Preferred Care is actively promoting this initiative to its constituents. Based on historical claims data we anticipate accessed care will be relegated to emergent situations or college students away from home.
- Preferred Care members are not permitted to select a MVP physician as their primary care physician at this time.
- If a Preferred Care member approaches your practice, ask to see his or her ID card. MVP suggests making a copy of the front and back and calling the number listed on the back to make sure the member is eligible. The member's home plan will dictate where claims are sent and other coverage requirements.
- You will be paid for covered services in accordance with the Preferred Care member's plan benefits.
- You will be paid your contracted MVP rate for identified services rendered.
- Reference materials and helpful tools to assist providers treating a Preferred Care member can be found on the MVP Web site (www.mvphealthcare.com). Please visit the MVP Web site and log in. On the provider home page, click on the link that says, "MVP Providers Treating Preferred Care Members". Information about where claims should be submitted, pre-authorization and claim requirements are listed here.

The expertise and quality of both Preferred Care and MVP's networks of healthcare professionals is widely known and highly regarded. We look forward to working with you to provide Preferred Care members the same great care that they are used to getting when they are away from home or attending college in the MVP service area.

"MyCare"

By Roberta L. Mitchell, Senior Account Representative

Recognizing the challenges our Practitioners have in caring for highly complex and high need patients, VMC applied for and received a \$75,000 grant from The State of Vermont, Department of Disabilities, Aging and Independent Living (DAIL). Under the grant, a business plan will be developed for a new health care delivery model for elderly or physically disabled Vermont adults who are found clinically eligible by DAIL, and for the high or highest need group under Choices for Care, Vermont's Long-Term Care Medicaid program. In the future DAIL may propose expanding the model to include all the Vermonters who are Medicare and Medicaid eligible.

VMC's Proposal

VMC will partner with Enhanced Care Initiatives (ECI) and Apex Benefits Services (Apex) to develop a business plan for the delivery of a new health care delivery model. Each of the three organizations brings their respective strengths to the partnership.

VMC is coordinating the RFP response. Through VMC's network and future contracting efforts, there will potentially be a subset of Medicaid Providers, contracts with specialty providers/facilities and services and case management in conjunction with ECI.

ECI is a care management company focused on providing hands-on-care and coordination through nurses, nurse

practitioners and social workers for the most complex and frail of the Medicaid and Medicare populations. In the delivery model, ECI will provide the one-on-one care management and will coordinate the care needs and fill-in the gaps that the patient has with providers and other resources in the community.

Apex Benefit Services will process claims and will provide technical support and project guidance as Apex has extensive experience serving the Medicare and Medicaid populations.

The VMC Board and DAIL will be actively involved in the development of the business plan and model. VMC, ECI and Apex have just begun the preliminary planning stages for this project.

Out of Network Services

By Susan Shane, Associate Medical Director, and Carol Palmer, Nurse Case Manager

Recent conversations with provider offices have made us aware that it may be helpful to review options for out of network services. Offices may be unaware of available specialists that participate with the three medical plans managed by VMC.

Remember that the specialty networks for Fletcher Allen Preferred, MVP, and TVHP extend beyond Vermont. Many members and providers seem surprised to learn that Dartmouth Hitchcock Medical Center is considered in-network for all three plans, and that MVP's network includes much of New York (including Albany and Rochester), and the Lahey Clinic.

Communication is critical to ensure a smooth referral process for our members. Prior to writing an out of network referral, we encourage you to contact a VMC case manager. Our case managers are excellent resources for identifying in-network specialists you may not be aware of, and can even explore the availability of appointments with those specialists.

Since we have a fixed medical budget to care for our members, and out-of-network costs are generally higher, it is financially prudent to encourage VMC members to utilize in-network expertise when available. Please feel free to call a VMC case manager at 847-8369 or toll free at 1-800-639-3881 for assistance with coordinating specialty care. They will be happy to help.

Spotlight on the VMC Web Site

By Kevin W. O'Neal
External Provider Relations Specialist

The benefits of web-based and electronic transactions are numerous and continue to bring cost savings to the VMC Network and all of our "Partners in Care." Elimination of paper, increased speed of transactions, reduction in errors, and greater data mining capabilities are just a few of the positive developments that have been realized with the use of The Internet and computers. VMC strives to take advantage of all that the web and computers have to offer.

One way we do this is by connecting our providers to the vast array of information found out on The Web. Point your browser to www.vermont-managedcare.org/Sitewide/links.html and you will find a comprehensive list of State and National healthcare links that include not just clinical care information, but also health care administrative organizations. From our home page, and actually every page on the VMC web site, you can access this list by clicking on "Important Links" found in the "red swirl" that reaches down from the VMC logo.

At the very top of the list are links to our "Network Facilities" and "Contracted Health Plans" pages where their web links can be accessed. You will also find a link directly to our Third Party Administrator (TPA), Apex Benefits Services, for the Fletcher Allen Preferred Medical Plans (FAP). From the Apex home page, you can enter the "Provider Portal" and access FAP member eligibility information, claim status, and authorizations.



As a reminder, on May 1, 2007, the NaviNet system currently used by Apex transitioned to an improved system called AboveHealth. Some of the improvements include eligibility search of 30 patients at a time, 'hover over' capability of explanation codes on authorization and claim searches, and printer friendly features on most screens.

All VMC Providers and their staff that currently access the NaviNet system have been contacted and new UserName and Passwords have been generated for use as of May 1st on the new Above Health system. If you are interested in accessing this web-based capability, please contact VMC Provider Relations at 802-847-8161 or toll free at 800-639-3881.

VMC continues to add to our list of "Important Links" for both National and State information. If you often visit a good healthcare site that you feel the rest of the VMC Network would benefit from, please forward to kevin.oneal@vtmednet.org. The VMC Web Site can be found at www.vermontmanagedcare.org.



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.

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

Vermont Managed Care
P.O. Box 1150
Burlington, VT 05402-1150

