

September 2003



Vermont Managed Care

Provider Newsletter

# PARTNERS *in* CARE

Vermont Managed Care  
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We encourage our readers to call or write us with your feedback about our newsletter. Contact Roberta Mitchell at 847-2528 or email to: roberta.mitchell@vtmednet.org

## Attention VMC/MVP Providers! MVP NIA Pre-Authorization Program

On September 15, 2003 a revised pre-authorization program was implemented for certain MVP members. National Imaging Associates, Inc (NIA) specializes in radiology benefit management and has entered into an agreement with MVP to administer a new pre-authorization program.

The plan types affected by this are

- HMO (includes POS plan types when in-network services are being rendered)
- CompCare
- Direct Access HMO
- Healthy New York

Pre-authorization is required for the following outpatient procedures

- CT Scans
- MRIs/MRAs
- PET Scans
- Nuclear Cardiology

This arrangement does not apply to MVP Health Insurance Company members (PPO, EPO, and Indemnity) or to MVP Select Care, Inc. members of self-funded groups, even if the plan has an HMO design.

**For VMC providers, you will no longer be calling VMC for pre-authorization for these procedures!!!**

**For pre-authorization call NIA:  
1-800-642-2602  
Monday – Friday, 8 a.m. to 8 p.m. EST**

### Please Note

- It is the responsibility of the ordering physician to obtain authorization.
- Practitioners rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in denial of your claim.
- Emergency room, observation and inpatient tests do not require pre-authorization.

### Some answers to some commonly asked questions

- Pre-authorization is not required for emergency situations. Imaging services that occur as part of observation services do not require pre-authorization.
- If the caller requesting the pre-authorization has sufficient clinical documentation, the requested service can be authorized during the first phone call. A pre-authorization number will be given to you over the phone.
- Multiple pre-authorization requests can be handled during one phone call.
- The pre-authorization number is valid for 60 days. If authorization expires before the imaging study is performed, NIA must be contacted again.
- Pre-authorizations approved prior to the September 15, 2003 NIA effective date will be honored.
- For “retrospective requests” please call NIA within 3 business days from the date the study was conducted to request authorization. NIA will review for the request for medical necessity.
- The policy is effective September 15. Claims for dates of service on and after September 15 that are not pre-authorized will not be paid and members must be held harmless.

### Why are we doing this?

MVP’s utilization in Vermont of certain imaging services is substantially higher than expected and is higher than national norms. Efforts to improve the appropriate utilization of resources are necessary both for the near-term financial benefit for our participating providers/facilities and also for the long-term survival of health insurance in Vermont.

If you would like a VMC Provider Relation’s representative to come to your office to help explain this new program, or have suggestions for other offices for us to visit, please call us at 847-8052.

MVP will also be holding Provider seminars this fall throughout Vermont and NIA Pre-authorization will be among the topics covered.

# HIPAA Deadline Approaching

October 16, 2003 is the “next” HIPAA deadline for the implementation of the Transaction and Code Sets for the exchange of electronic claims information. For the electronic transaction rule, Congress enacted legislation allowing covered entities that qualified for the extension to have until October 16, 2003 to meet the electronic transaction standards. Small health plans must still meet the October 16, 2003 compliance date and were not eligible for an extension.

Under HIPAA, all health care plans must have the ability to send and receive electronic data interchange (EDI) claim submissions, remittance advices, claim status inquiries and responses, enrollments and benefit maintenance, eligibility inquiries/responses, premium payments, and healthcare services review (referral) requests and responses in standard format by October 16, 2003. The HIPAA standard format is the ANSI X-12N, Version 4010A.

Currently, there are many unique formats used to process EDI transactions. Under HIPAA, standardization of data fields is required. Standardization of data fields will be implemented by specifying uniform definitions of the data elements that will be exchanged in each type of electronic transaction. As a health care provider it is your responsibility to implement the required data elements for the electronic transactions that you send to health plans. Some clearinghouses will not be able to transmit HIPAA-compliant EDI by the October deadline.



Numerous web sites are available for guidance pertaining to HIPAA and the transaction and code sets.

- United States Department of Health and Human Services  
[www.aspe.hhs.gov/admsimp/](http://www.aspe.hhs.gov/admsimp/)
- Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov/hipaa/hipaa2/default.asp](http://www.cms.hhs.gov/hipaa/hipaa2/default.asp)
- NHV SHIP The NH and VT Strategic HIPAA Implementation Plan  
[www.nhvship.org](http://www.nhvship.org)

The following code sets must be used for all EDI transactions as of October 16.

- *International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2*
- *International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volume 3 Procedures*
- *Center for Medicare and Medicaid Services Common Procedure Coding System (HCPCS) and the Current Procedural Terminology, Fourth Edition (CPT)*

HCPCS Level 3 codes (local codes) cannot be used for EDI transactions. All local codes have been eliminated under HIPAA.

VMC encourages you to contact your contracted health plans directly to ensure you are HIPAA compliant.

Note: Information contained in this article was taken from a compilation of sources, including MVP's Monthly Memo August 2003 and September 2003.

# VMC Employee Spotlight

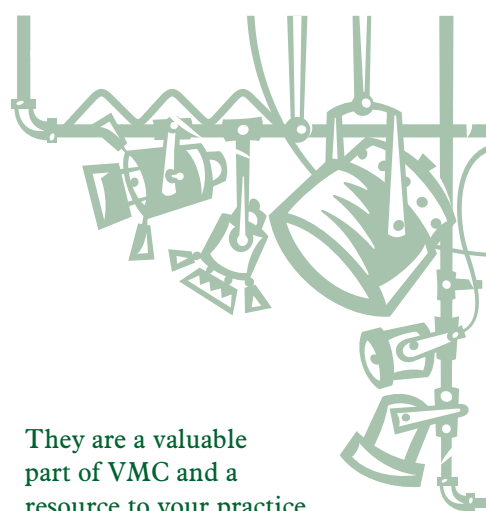
*VMC is adding a new feature to our Newsletter called the VMC Employee Spotlight. This segment of the newsletter will feature a VMC department and will provide you with background of what that department does and the staff in that area.*

## Network Profile Specialist

For our first issue, we would like to introduce you to our Network Profile Specialist Area. This area is part of the Provider Relations Department and is staffed by Jodie Couture and Kelley Roy. For all of the VMC Contracts, this area is responsible for obtaining all demographic, billing, and credentialing information from our participating providers and submits it to MVP, TVHP and EMI (for FAP).

Whenever there is a change to your practice profile, either adding a new provider, removing a departing provider or simply changing some information,

Jodie and Kelley are the two individuals at VMC that coordinate and implement this with the payers on your behalf. Some of the changes they receive on a daily basis include, opening or closing your practice to new patients, noting a new board certification, a change in your Tax Identification Number that affects your claim reimbursement, and practice mergers. One of the challenges Jodie and Kelley are faced with is ensuring your information is implemented in a timely fashion. In order to meet this goal, VMC requires our network providers give us a 60-day prior written notification of any modification to your practice profile. This allows Jodie, Kelley and the VMC contracted payers enough time to implement your modifications. Jodie and Kelley are managing a network of over 2,600 providers throughout Vermont and New Hampshire.



They are a valuable part of VMC and a resource to your practice. You may contact either of them at the numbers listed below.

Jodie H. Couture	802-847-8056
Kelley Roy	802-847-6242
Confidential Fax	802-847-3427

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## Summary of PT Benefits and Referral Requirements

### TVHP

Maximum of 30 combined OT, ST and PT visits per calendar year. Chronic care not covered. PCP referral required for all visits, including additional visits beyond initial referral.

Fax referral form to VMC at 802-847-6213.

### MVP HMO

Two month limitation for acute conditions only. PCP referral required for PT/OT visits. All Specialists have the option of completing referrals for PT/OT. If the Specialist does not complete the referral it must be obtained from the PCP. PT/OT referrals are valid for 2 months per diagnosis.

Fax referral form to VMC at 802-847-6213.

On-line referral submission is available [www.mvphealthcare.com](http://www.mvphealthcare.com)

### MVP SelectCare/ASO

Two month limitation for acute conditions only. PCP referral required for PT/OT visits. All Specialists have the option of completing referrals for PT/OT. If the Specialist does not complete the referral it must be obtained from the PCP. PT/OT referrals are valid for 2 months per diagnosis.

Fax referral form to MVP at 888-819-2103.

On-line referral submission is available [www.mvphealthcare.com](http://www.mvphealthcare.com)

### MVP PPO

Referrals are not required. Covered for up to 30 PT/OT visits per calendar year. Rider, for 60 visits total, available to large employer groups only.

### FAP

Referrals are not required. Up to 30 combined PT/OT/ST visits per year.

### Reminder about referrals

For PT referrals to facilities (such as Copley Hospital, FAHC, Porter or Northwestern Medical Center) please write the referral out to the facility and not to the individual therapist.

## Office-Based Administered Injectable Drugs & Vaccines

In 2002, VMC removed the withhold requirement for office-based administered injectible drugs and vaccines. Since then, VMC has received inquiries from providers about the reimbursement methodology. The following information explains how each of the VMC contracted payers are processing your claims for these services.

### MVP & Employers Mutual Inc. (EMI)

MVP and EMI implemented a 0% withhold associated with all office based administered injectible drugs and vaccines. Therefore, the withhold amount on MVP and EMI's Remittance Advice will show as \$0.00.

### The Vermont Health Plan (TVHP)

BCBSVT on behalf of TVHP is only able to implement one withhold amount for the VMC network which is currently 15%. VMC requested that the maximum allowable reimbursement for office-based administered injectible drugs & vaccines be grossed up by 15% to compensate for the system limitation. On your TVHP Remittance Advice you will see a 15% withhold applied to office-based administered injectible drugs and vaccines, however, the maximum allowable amount has been increased for the TVHP Product to allow for a cost neutral impact to you.

Should you find that your claims are not being processed appropriately, please contact your VMC Provider Relations Representative or VMC Customer Service at 800-639-3881.

# Fletcher Allen Preferred & Preferred Plus Plans (FAP)

## 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

## Patient Liability for Facility Services

We are pleased to report that as of the last week in July 2003, EMI has completed the necessary programming to correctly identify the patient's liability for facility based services on the Statement of Remittance (SOR). Prior to this change the withhold amount was being reported under the patient liability column (in error). The withhold is not a patient liability and should not be billed to patients. While EMI reprogrammed their claims system, reports were generated for the hospitals that correctly identified the patient liability amount. Questions pertaining to a FAP member's facility account can be directed to VMC Customer Service at 866-582-6836.

We want to extend a special thank you to the hospital billing staff for your patience and cooperation over the past few months, we greatly appreciate it.

## Code Review Update

On July 15, 2003, CodeReview™ was implemented for FAP member claims submitted to Employers Mutual, Inc. To date, VMC has received a minimal number of inquiries from our network about the implementation. We will evaluate the effectiveness of this implementation as time goes on and we will share this information with you in future issues. Questions or concerns about this implementation can be directed to your VMC Provider Relations Representative or Martita Giard toll-free at 866-582-6836.

# MVP Plans, ID Numbers, Referrals

## ID Numbers

It's been a year since MVP member identification numbers have been changed to be HIPAA compliant and many providers are still frustrated in trying to determine to what plan a member belongs. Determining a member's ID number and plan may be accomplished through the following sources.

- Member's ID Card – The card denotes the plan type the member has, the state from which the benefits are derived (New York or Vermont), whether a referral is necessary, copayment and coinsurance information, and listing of eligible dependents.
- MVP Member Services Departments 1-888-687-6277
- MVP Web Site [www.mvphealthcare.com](http://www.mvphealthcare.com)

## Referrals and Authorization Review

- For MVP HMO members who are enrolled with PCP's in the VMC network, referrals and authorization review\* are done by VMC. Please fax referrals to VMC at 802-847-6213 or submit the referral online to MVP via [www.mvphealthcare.com](http://www.mvphealthcare.com)  
\*Exception is pre-authorization for certain imaging procedures are now done by NIA (see article on page 1 of this newsletter).
- For MVP PPO members whose residence is in the VMC service area all authorizations are done by VMC (there are no referral requirements for PPO).
- For MVP SelectCare/ASO members referrals and authorizations are done by MVP. Referrals are to be faxed to MVP at 1-888-819-2103 or may be submitted on-line. Pre-Authorization is done by MVP by calling 800-229-5851 ext.21 or faxing to 518-386-7764.

Note: Please see the VMC Provider Manual Payer Matrices for complete details. Payer Matrices are also found on the VMC web site, via "Provider Relations/Operational Tools".



To check member eligibility, please logon to MVP's Web site ([www.mvphealthcare.com](http://www.mvphealthcare.com)) or contact Member Services at (888) 687-6277 (MVP-MBRS).

## MVP Survey Winner

In the June edition of VMC "Partners in Care" provider offices contracted with MVP were asked to complete a survey evaluating MVP's services.

VMC is pleased to announce that the survey completed by Franklin County Surgical Associates of St. Albans, Vermont was randomly selected and received the MVP prize. (Way to go Bonnie!)

Even though the submission deadline for the prize has passed please feel free to still submit the survey to VMC. We welcome your input. The results of the survey have been shared with MVP.

## MVP Gastroplasties Performed at FAHC

Effective August 1, 2003, MVP "gold-carded" Fletcher Allen Health Care as a facility that no longer requires pre-approval to perform gastroplasties. MVP's Medical Directors reviewed gastroplasties performed in Vermont hospitals and developed a new policy defining the pre-approval criteria for surgeries on a case-by case basis. FAHC was recognized as a facility that performed a high volume of gastroplasties with high quality outcomes.

The "gold-card" status for gastroplasty allows surgeons to perform the surgeries at Fletcher Allen Health Care without first seeking pre-approval. The physicians are still required to notify VMC for HMO members and MVP for SelectCare/ASO members of this elective procedure five days prior to the scheduled date.

**Reminder**  
**Please remember to fax all**  
**TVHP referrals to VMC,**  
**not to BCBSVT!!**

## **BCBSVT Expands its Web Site**

Blue Cross and Blue Shield of Vermont (BCBSVT) has expanded its web site [www.bcbsvt.com](http://www.bcbsvt.com). A brief summary of the features available for BCBSVT and The Vermont Health Plan (TVHP) are listed below. For additional information regarding the web site please contact your TVHP Provider Relations Representative at 888-449-0443.

### **Providers may**

- Submit claims
- Check claim status
- Check eligibility of members

### **Employers may**

- E-mail the Plan using a secure site and receive answers electronically
- Read the Plan's Manual for Group Benefits Managers

### **Brokers may**

- Order forms and supplies
- Read information about the Plan's commission programs

### **Members may**

- Read about their personal benefits and link to specific contract documents
- Check status of claims
- E-mail the Plan using a secure site and receive answers electronically

For these functions, you must register with the site and then use a login name (which you'll receive by e-mail) and a password (which BCBSVT will send you through US mail for your protection).

## **VMC's Strategic Plan**

At the VMC Board of Directors retreat this past February, the Board reviewed the local health care market in the context of the national environment of health care, and assessed VMC's strategic position. In formulating its vision for VMC's future, the Board reviewed existing goals and approaches, discussed implications of the current vision, and selected approaches for future directions. The Board agreed that VMC's vision is to sustain and enhance VMC's marketable value to payers and providers by:

- Enhancing clinical effectiveness of VMC physicians and hospitals;
- Investing in early detection and treatment of chronic disease;
- Extending care management to more diagnoses and conditions; and
- Providing fair compensation with reasonable and low burden administrative policies and procedures.

In carrying forward the decisions of the VMC Board, we have been reviewing clinical data and have found areas of wide variance in the way that different patients are treated for the same condition. One prominent example is the management of Carpal Tunnel Syndrome (CTS). VMC is working with clinicians in our network who treat this syndrome frequently and we are working to identify ways to reduce the variation and improve the clinical care of patients.

As a PHO Network, we are all encouraged to participate in meeting VMC's strategic goals. A copy of the VMC Strategic Plan has been sent to the physicians in our Network and it is VMC's desire to have the physicians in our network guide our direction. As we take on additional projects to meet our goals we will be calling on you to assist us. If you are interested in participating in any of these efforts, please contact Martita Giard, Director of Network Development & Provider Relations at 802-847-8065 or toll free at 800-639-3881.

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## **Provider Directories**

VMC encourages our provider network to use the provider directory feature on our web site or those of our VMC contracted payers. As you may be aware, the paper versions of provider directories are produced once or twice a year depending on the printing schedule and there are many changes within the network between printings. If you use the paper directories to identify providers that are in-network for clinical referral purposes, we encourage you to access more up-to-date information through VMC, MVP or BCBS/TVHP web sites. The Provider Directory look up feature can be found on the following websites.

VMC's: [www.vermontmanagedcare.org](http://www.vermontmanagedcare.org)

MVP's: [www.mvphealthcare.com](http://www.mvphealthcare.com)

TVHP's: [www.bcbsvt.com](http://www.bcbsvt.com)

# Spotlight on the VMC Web Site

## *“Quick-Links” and where they take you*

While “surfing” the VMC Web Site, you will notice the red “swirl” in the upper left hand corner of the page. This swirl contains the VMC Web Site “Quick Links”.

“Quick Links” were developed to provide users with instant access to some of the more frequently used locations and functions of the VMC Web Site, no matter where in the web site you currently are. These links will follow the user from page to page, providing a quick direction change and access.

### **“Quick Links” include the following:**

“Provider Search” discussed in the last issue of the VMC Newsletter;

“VMC Newsletter” The “VMC Newsletter” section provides an electronic copy of the current VMC Newsletter, bullets of topics found in the current VMC Newsletter, and archived copies of past VMC Newsletters;

“Important Links” The “Important Links” section of the VMC Web Site is a collection of State and National resource links that cover all aspects of the healthcare industry, from administrative to clinical information. We are always looking to expand this collec-



tion. Please contact VMC Provider Relations with suggestions for additional links, or if you encounter problems with any of the current links. This page also includes links to VMC Contracted Payers, and VMC Network Facilities; and

“Ask VMC” “Ask VMC” is a form that allows the user to quickly submit a formal written request or question to Vermont Managed Care. Some of the requests available via this format include notification of practice status change, request for meeting with Provider Relations, requesting a copy of the VMC Fee Schedule, or even to simply request a call back. This format is not a “secure” format, so we ask that no confidential clinical information be submitted via “Ask VMC”.

## VMC Reimbursement Schedule Update

The VMC reimbursement schedules for MVP, TVHP and FAP have been updated with approximately 150 new 2003 CPT codes effective October 1, 2003. Recent billings by our network providers, in addition to specific requests for pricing, resulted in the need to price these new codes. The codes include, but are not limited to, laparoscopic, urologic/gynecologic, and radiologic procedures.

Should you desire a copy of the updated codes and reimbursements, please complete the request form inserted in this newsletter and fax it to Vermont Managed Care Provider Relations Department at 802-847-6214.

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## Skin Lesion Prior Authorization

Excision of skin lesions requires prior authorization if it is considered to be cosmetic in nature and the member is seeking payment for the procedure under the Plan’s benefits. Skin lesions that are suspicious for malignancy, irritated or cause bleeding are not considered cosmetic and are considered medically necessary. When submitting a prior approval request, please provide as much detail as possible describing the reason for the excision. In the next update to the VMC Provider Manual, wording will be included in Section 4 - Payer Matrices to better clarify cosmetic vs. medically necessary.

# VMC Board of Directors

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Jeffrey Wasserman  
Fletcher Allen Health Care  
VP, Medical Group Mgmt.

Stephen Mason, MD  
Vermont Anesthesia Consortium  
Northwestern Medical Ctr. PHO

\* Board Officers

## Vermont Managed Care Contact Numbers



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

802-847-8161	802-847-6214	
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### Care Coordinators

802-847-8369	802-847-6212	802-847-4862
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### Customer Service

802-847-8369	802-847-6213	802-847-4862
800-639-3881		866-582-6836

### Provider Enrollment

802-847-8161	802-847-3427
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\*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.

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

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





## Request for New 2003 CPT Code Reimbursement Schedule

If you would like a list of new 2003 CPT codes and reimbursement rates added to the 2003 VMC Reimbursement Schedules for MVP, TVHP and the Fletcher Allen Preferred Plans, please select the plan(s) for which you are requesting codes, complete the form and fax it to the number listed below. You will receive reimbursement information for only those plans in which you participate with VMC.

If you would like to receive the codes via email, please be sure to include your email address.

**Please note the reimbursement schedule for the new codes go into effect October 1, 2003.**

Plan(s):                     MVP             TVHP             Fletcher Allen Preferred and Preferred Plus

Name: \_\_\_\_\_

Group or Hosp. Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email address: \_\_\_\_\_

Fax to:                    Provider Relations Department  
 Vermont Managed Care  
 (802) 847-6214

**FOR VMC USE ONLY**

Received	Plans	Verified	Sent
	<input type="checkbox"/> MVP <input type="checkbox"/> TVHP <input type="checkbox"/> FAP		