



PARTNERS in CARE

November 2011

From the Desk of the Medical Director

Influenza Testing

As fall progresses, so does awareness of the upcoming flu season. Although we know that vaccination is the mainstay of influenza healthcare, questions arise on a regular basis about diagnosis and treatment. The actual benefit of anti-viral therapy remains one area of discussion, another being the performance characteristics of laboratory tests, how to use them, and how they impact clinical practice.

Selected Points About Testing:*

- **Clinical Judgment** during flu season is >60% sensitive, with >75% positive predictive value, which is sufficient for diagnosis and treatment in most routine cases.**
- **Test Sensitivity** in actual clinical practice may be lower than in the research setting due to patient selection, timing of tests, collection technique, lab performance, etc.
- **Rapid Influenza Diagnostic Tests (RIDT)** sensitivity may be 50% or less (lower after 72 hours of symptoms, with increasing age, during non-flu season, and for H1N1).
- **Culture** sensitivity may range from 50 - 95% (reported as low as 35% for people >50).
- **Polymerase Chain Reaction (PCR)** is the most sensitive test, is highly specific, and is now often used as a gold standard.

Some Key Points About Using Test Results:

- 1) During flu season, if a patient has typical flu symptoms, usual flu treatment should be provided and not delayed, and generally no testing is indicated.**
- 2) A positive RIDT is only highly specific during peak flu season (many more false positives at other times, possibly warranting confirmatory testing). RIDT is insufficiently sensitive to base treatment decisions on a negative result.
- 3) Additional testing after a negative RIDT is not routinely warranted, but may be helpful if a positive result will change patient management or influence infection-control measures.
- 4) PCR or IFA (Immunofluorescence) may be considered when testing is indicated for acute care if the results are available in an actionable time-frame. Cost can be up to 10 times that of RIDT.
- 5) Acute testing may be useful for:
 - a) Early diagnosis and treatment for atypical cases or select high-risk patients.
 - b) Early detection in a hospital or institutional setting.
 - c) Avoidance of additional unnecessary diagnostics or antibiotics. ***
- 6) If needed for epidemiological or surveillance purposes, testing should be done per CDC, state, or institutional guidelines.

*Available tests range from point-of-care tests to full subtype characterization. An overview can be found in the IDSA guidelines. An in-depth discussion of RIDTs is at www.cdc.gov/flu/professionals/diagnosis/clinician_guidance_ridt.htm.

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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

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******If antiviral medications are used, empiric treatment without testing is most cost-beneficial when the likelihood of influenza is above 20-30%; this threshold drops steeply for the less expensive drugs. [*Annals of Family Medicine* vol. 2:1 p.33, 2004]

******* Several studies have demonstrated this in febrile infants and children during flu season, with a cautionary finding of some concomitant UTI's in male infants

IDSA Guidelines for Seasonal Influenza in Adults and Children *Clinical Infectious Diseases* 48:1003 (15 April, 2009)

Influenza Testing in 2012, *Advance for Administrators of the Laboratory* vol. 20:8, p.36, Sept. 23, 2011

Abe Berman, Director of Finance

Abe assumed the role of Director of Finance on October 17, 2011. He will be responsible for the Finance and Analytics & Reporting departments at VMC. Abe's broad background includes, most recently, managing revenue cycle performance for Fletcher Allen Health Care. In this role, Abe oversaw the performance reporting, analysis, and improvement for the overall revenue cycle, as well as the maintenance, monitoring, and improvement of the charge master, pricing strategy, and charge capture process.

Prior to joining Fletcher Allen, he was a Financial Analyst for Bruegger's Enterprises, Inc. He started his career as an auditor for Ernst & Young, LLP in New York. He holds an MS in Accountancy from the University of Notre Dame as well as a Bachelor's degree from New York University. Abe is currently on the Board of Directors for the NH-VT Chapter of HFMA and has been a member since 2006.

Coding News

The Pitfalls and Dangers of "Cloned" Notes

As the electronic age of medical documentation tries to streamline the practice of charting, new dangers have come to the foreground. According to the OIG 2011 Work Plan, they will be reviewing the "extent of potentially inappropriate payments for E&M services and the consistency of E&M medical review determinations." CMS's Medicare Claims Processing Manual, Pub. No. 100 - 04, ch. 12, § 30.6.1 instructs providers to "select the code for the service based upon the content of the service" and says that "documentation should support the level of service reported." Having said that, Medicare contractors have noted an increased frequency of medical records with identical documentation across services, prompting them to also review multiple E&M services for the same provider and beneficiaries to identify EHR documentation practices associated with potentially improper payments. It also appears that Medicare is starting to deny claims for EHR cloning. EHRs often have "templates" to pull forward desired information. However, these templates are merely a tool and should in no way be construed as the end-all or be-all of the note documentation. All documentation in the medical record should be patient specific. The carry over of identical information from date-to-date causes the appearance of the medical record being cloned vs. actual data being collected due to the medical necessity at the time of the visit. It is, therefore, necessary for the practitioner to verify the information pulling forward as appropriate for that visit. Only cite pertinent and substantiated information with the day's findings.

Since other organizations are starting to see denials, it is, therefore, extremely important that the documentation being pulled into the patient's note from the EHR is not a "clone" of the previous visit or identical to another patient being treated for the same problem(s).

VMC Care Management Department Annual Notices

UM Availability

The Care Management Department is available to you 24 hours a day, 7 days per week to assist with Utilization Management determinations. During normal business hours, you can call us directly through our local or toll free numbers listed below. On weekends, holidays, and after-hours you can access assistance by contacting the on-call Nurse Case Manager by pager. If a Medical Director is needed, the on-call nurse will coordinate this. To assist members with UM issues whose primary language is not English, VMC will arrange for interpretive services as needed without charge.

Local Number(802) 847-8369
Toll Free Number.....(800) 639-3881
On-call Pager (Toll-Free).....(888)-586-8476
TTD.....(802) 847-4747
Normal business hours are M-F 8:00 a.m. to 4:30 p.m.

UM Criteria

Annually, the Care Management Committee of the Board reviews and approves the utilization management criteria for use as guidelines and benchmarks to inform the Care Management process. The most current versions of the following criteria are approved for use by the Care Management Sub-Committee of the VMC Board of Directors.

Area of application

Criteria

Inpatient, Home Care, Case Management
Recovery Facility, Surgical Procedures,
Imaging and select DME items.....Milliman Care Guidelines

New technology.....Hayes Directory

Other criteria sets are also approved for reference. These include "Apollo's Medical and Rehabilitation Review Criteria," "Therapy Referral Handbook, Second Edition" and the "APTA Guide to Physical Therapist Practice, Third Edition."

External Review firms contracted to provide specialty review services include American Medical Review (AMR) Medical Review Institute of America (MRIoA) and MCMC II.

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 under UM Availability.

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 Case Manager. They will work with you 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. UM decision making is based only on the appropriateness of care and service and the existence of coverage. VMC does not specifically reward

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Annual Notices *continued*

practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not in any way encourage decisions that result in underutilization. VMC regularly monitors utilization trends to evaluate and encourage appropriate utilization of services. This policy can be found in the VMC Utilization Management Plan on our website. 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, Case Managers, Client Account Representatives, Managers or anyone involved in Utilization Management decisions.

UM Policies

The Utilization Management Policies are provided to you in the VMC Provider Manual. You may access the following policies on the VMC Website, including but not limited to:

- The Utilization Management Plan
- Grievance (Appeal) Policy
- Transition of Care Policies for Members
- Specialist as PCP Policy
- Inpatient Review Policy
- Pre-Approval Procedures and Forms
- Review Timeframe Policy
- Many other helpful policies and information

The policies have recently been reviewed and revised. The updated policies can be accessed on the VMC website, www.vermontmanagedcare.org, or by calling VMC at the numbers listed above.

Spotlight on the Web

Updates since the last VMC Newsletter include:

◇ Newly credentialed providers are available on the VMC web portal. To view the last three months of additions and archived listings please go to: www.vermontmanagedcare.org/providers/credentialing/newproviders

VMC:

◇ **Leave of Absence (LOA) Policy 03-01 updated 08/08/2011:**

www.vermontmanagedcare.org/Providers/Provider_Manual03.html

◇ **Organizational Chart:** www.vermontmanagedcare.org/About_VMC/index.html

◇ **Phone list:** www.vermontmanagedcare.org/Providers/Provider_Manual/01.html

FAP:

◇ **Pre-Approval Form to include addition for head CT and MRI effective 08/01/2011:**

www.vermontmanagedcare.org/Providers/forms.html

◇ **Apex Benefits Services Access Form** (this will allow providers to verify Fletcher Allen Preferred and Preferred Plus members' eligibility and claims status, etc.): www.vermontmanagedcare.org/Providers/forms.html

The VMC Web Site can be found at www.vermontmanagedcare.org. If you have questions please call your VMC External Provider Relations Representative, Carrie Germaine or Elizabeth Roach, at 802-847-8161 or toll free at 800-639-3881.



Events & Notices

VMC Employee News

Over the past several months, VMC has had several staff changes. We would like to welcome and congratulate our newest VMC employees and those who have been promoted. In addition, we would like to bid farewell to some friends who have left VMC for other opportunities or are moving on to new adventures.



New Employees:

- Emily Bartling, RN, BSN, Nurse Case Manager
- Deborah Safford, External Provider Relations Specialist
- Sarah Santor, Staff Accountant
- Tammy Villnave, Client Account Representative

Career Moves:

Tom Dettre, who has been VMC's Finance Director for the past 8 years, is assuming the new position of Financial Strategist.

Tom assumed his new role on October 17, 2011, and will be responsible for much of the financial support, including financial modeling, risk mitigation, and other analysis, behind VMC's evolving role in health reform and other strategic initiatives.

Employee Promotions:

Sandra Barbieri was promoted from Staff Accountant to Senior Staff Accountant.

Departures:

- Yolande Franklin, Client Account Representative
- Jane Suder, RN, Clinical Process Analyst
- Jeanette Iverson, RN, CCM, Case Manager
- Geraldine Smith, RN, CCM, Case Manager

You may continue to have the opportunity to interact with Jeanette and Geraldine as they are staying on as Per Diem employees after retirement.

Leave of Absence Policy Update

The leave of absence Policy has recently undergone revision to more closely align with area hospital requirements. Any provider who plans to take a leave of absence greater than ninety days, but less than twelve months will be required to complete a leave of absence request form. This form will outline the reason for the leave, the duration of the leave and how his/her members will be managed during the leave, as applicable. The VMC Credentials Committee will review the leave of absence request and approve the leave or request further information as needed. Prior to the provider returning to active Network Participation a "Return from Leave of Absence Request Form" must be completed and submitted to the VMC Credentials Committee for review and approval. While on leave, providers remain subject to all credentialing requirements including, but not limited to, current licensure, current DEA, board certification maintenance, continuous liability insurance coverage (if engaged in any clinical practice during the leave) or evidence of tail coverage (if not engaged in clinical practice during the leave of absence) and the reappointment process as scheduled. Should you have any questions or need help accessing the request forms, please contact your External Provider Relations Representative, Elizabeth Roach or Carrie Germaine, at 802-847-8161 or 800-639-3881.

Coming in November 2011

Vermont Managed Care's Provider Satisfaction Survey will again be available through Zoomerang's online service. A reminder notification will be sent either by email or post card. VMC will be offering five randomly drawn prizes worth \$100 each for survey participants. VMC values our network providers' feedback regarding our performance, and we look forward to your input on our performance over this past year. Should you have any questions, please contact your External Provider Relations Representative, Elizabeth Roach or Carrie Germaine, at 802-847-8161 or 1-800-639-3881.



Network Brag Board

Middlebury Family Health Becomes First Vermont Practice to Achieve Meaningful Use

Middlebury Family Health (MFH) is the first practice in Vermont to achieve Meaningful Use and all four physicians, Dr. Jean Andersson-Swayze, Dr. Eileen Doherty-Fuller, Dr. Dayle Klitzner and Dr. Linn Larson, have received their first \$18,000 incentive payment from Medicare.

In 2010, the physicians decided to focus on achieving Meaningful Use and Medical Home certification.

In order to do this, they would need to implement an Electronic Health Record (EHR) system and decided on a computer software program called Medent. Medent was pre-loaded with many of the necessary reports needed to prove Meaningful Use and achieve a Level 3 Certification for Medical Home. A lot of time was spent in the early stages working with the vendor on additional elements and reports needed.

Along with this achievement, Middlebury Family Health also became certified as a Level 3 Patient-Centered Medical Home in July 2011 and, in doing so, will receive the highest level of payment for participating in the Vermont Blueprint for Health Program.

Office Manager, Stacy Ladd, said, "There is considerable commonality in what is needed for Meaningful Use and Medical Home. For both, we're focused on three chronic diseases: diabetes, hypertension, and hyperlipidemia." Michelle Clark added, "Meaningful Use was in place, and we were able to use it for Medical Home. Medical Home is not a one-time deal. It requires reports continuously or monthly or quarterly. We're able to easily locate and pull the data needed, such as triage response time, vital signs, or number of well-child visits."

"The combination of having a great staff that was willing to take on such a huge challenge and a superior Electronic Health Record made this goal a reality for our practice. In the near future, MFH will be preparing for Stage 2 of Meaningful Use and monitoring and improving patient care," says Stacy.



Left to Right: Jean Andersson-Swayze, MD, Eileen Doherty-Fuller, MD, Dayle Klitzner, MD, and Linn Larson, MD



Steve Leffler, MD, Named Chief Medical Officer

Steve Leffler, MD, has been named Chief Medical Officer of Fletcher Allen after serving in the role of Medical Director of the Emergency Department since 2006. He also currently serves as the president of the Fletcher Allen Medical Staff.

As CMO, Dr. Leffler will serve as the senior clinical executive responsible for Medical Staff affairs, the Jeffords Institute for Quality, medical technology management and medical ethics. As a member of senior management, he will participate in strategic decision-making and strategy development for our academic medical center, bringing with him 18 years of service to the organization. He will also provide leadership in helping to develop a regional integrated system of care, drawing upon his experience working with other hospitals in the region.

Dr. Leffler has served on numerous clinical committees during his tenure as a Fletcher Allen ED physician and has been a key collaborator on significant organizational initiatives. Those include Fletcher Allen's regional STEMI project, an innovative program to ensure heart attack victims receive life-saving care as rapidly as possible. He is a professor of Surgery at the UVM College of Medicine and a past president of the Vermont Chapter of the American College of Emergency Physicians.

Network Brag Board *continued*

NMC Recognized as a Top Performer on Pneumonia Care

Northwestern Medical Center (NMC) is pleased to announce that the Joint Commission has recognized NMC as a Top Performer on Key Quality Measures in the area of pneumonia care. NMC is the only hospital in Vermont to earn the "Top Performer" designation. For the first time, the Joint Commission's 2011 annual report on quality and safety, *Improving America's Hospitals*, lists hospitals and critical access hospitals that are top performers in using evidence-based care processes closely linked to positive patient outcomes.

"Our staff works very hard to incorporate evidence-based practice, based on sound scientific evidence for the best patient outcomes," says Celeste Kane Stebbins, RN, Med/Surg/ICU Nurse Manager at Northwestern Medical Center. "We are thrilled to be recognized for our work in this area."

As a Top Performing Hospital, NMC is among 405 hospitals being recognized for 2010, which represents the top 14 percent of Joint Commission accredited hospitals (of those that report core measure performance data).

On the core measure of pneumonia, NMC has consistently met this mark. "The strength of the Core Measures is that they are really grounded in science," says Jane Catton, RN, NMC's Chief Quality Officer/Director of Process Improvement. "They are not put out there with the directive to 'do it because we want you to,' but rather they have been carefully researched and have scientifically shown they will improve outcomes. I am proud of the hard work of our staff to earn this designation from the Joint Commission."

The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 19,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

For more information regarding the Joint Commission's Top Performer designation, please visit www.jointcommission.org/accreditation/top_performers.aspx. For more information about quality measures at NMC, please visit www.northwesternmedicalcenter.org/hospitalreportcard.

Copley Hospital Completes Attestation for Electronic Health Records (EHR)

Copley Health Systems recently completed attestation to the federal government that Copley Hospital has met Meaningful Use criteria for the Phase One implementation and use of its electronic health record (EHR) and is eligible for Medicare EHR incentive payments. Copley completed attestation on June 27, 2011, the first hospital in Vermont to do so. The attestation demonstrates to the Centers for Medicare & Medicaid Services that Copley Hospital has met requirements for EHR Medicare incentives under the American Recovery and Reinvestment Act of 2009.

"Our focus has been to improve the quality of patient care and patient safety in addition to improving the exchange of information among healthcare providers and patients through our EHR," said Mel Patashnick, President of Copley Health Systems. "Our being at the forefront of implementing this vital technology is indicative of our commitment to providing outstanding patient care."

Copley is using CPSI as its EHR platform. A number of employees, including physicians, nurses, pharmacists and other clinical staff, were involved with process preparation, the selection and installation of the appropriate software and training for implementation to meet Meaningful Use guidelines. Copley has also worked closely with Vermont Information Technology Leaders to build a bi-directional health record interface, enabling transmissions to and from the Vermont Health Information Exchange (VHIE). Copley's EHR Phase One implementation was funded in part by a grant from the Lucy D. Nisbet Charitable Fund.

Copley Hospital is the non-profit community hospital serving the greater Lamoille Valley area of north-central Vermont. This rural hospital is a vital resource for the wellness and health of the community in addition to being one of the largest employers in that area. Copley provides 24/7 emergency services, women's and children's health services, access to more than 50 specialists, including a full-time cardiologist, urologist and a state-of-the-art orthopedics program on its campus in Morrisville, Vermont. Copley provided more than \$800,000 in direct charitable care last year and has provided \$5.5 million in community benefits for the surrounding area.



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Vermont Managed Care Contact Numbers



Business Line	
Phone #	Fax #
802-847-8161	802-847-6214

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

Provider Enrollment (PE) / Provider Relations (PR) / Credentialing	
Phone #	Fax #
802-847-8161 or 800-639-3881	802-847-3427 (PE) 802-847-6214 (PR) 802-847-6254 (CRED)

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