

# CONFERENCES

<p><b>19TH ANNUAL EASTERN WINTER DERMATOLOGY CONFERENCE</b></p> <p><b>January 18-21, 2008</b> Stoweflake Hotel &amp; Conference Center Stowe, VT</p> <p><b>For more information</b> call UVM CME at 802-656-2292 or visit their website at <a href="http://cme.uvm.edu">http://cme.uvm.edu</a></p>	<p><b>7TH EMERGENCY MEDICINE UPDATE CONFERENCE</b></p> <p><b>January 30- Feb. 2, 2008</b> Stoweflake Hotel &amp; Conf. Center Stowe, VT</p> <p><b>For more information</b> call UVM CME at 802-656-2292 or visit their website at <a href="http://cme.uvm.edu">http://cme.uvm.edu</a></p>	<p><b>17TH ANNUAL CURRENT CONCEPTS &amp; CONTROVERSIES IN SURGERY</b></p> <p><b>January 31 - February 2, 2008</b> Topnotch Resort and Spa Stowe, VT</p> <p><b>For more information</b> call UVM CME at 802-656-2292 or visit their website at <a href="http://cme.uvm.edu">http://cme.uvm.edu</a></p>
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## Vermont Medical Society 195th Annual Meeting

October 25, 2008  
Topnotch Resort & Spa, Stowe, Vermont

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VERMONT MEDICAL SOCIETY  
PO Box 1457  
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# THE GREEN MOUNTAIN PHYSICIAN

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*"Not for  
Ourselves do  
we labor"*

VMS motto

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## VERMONT IS THE HEALTHIEST STATE IN THE NATION



Montpelier (Nov. 5) – Vermont is the healthiest state in the nation, according to the 2007 edition of America's Health Rankings, released today by the United Health Foundation. This is the first time Vermont has captured the top spot, climbing steadily from being ranked eighth in 2001. Vermont surpassed the previous leader, Minnesota, which was ranked second this year.

According to the United Health Foundation, Vermont is among the top 10 states in 14 of 20 measures. The state's strengths include high immunization coverage with 86 percent of children between the ages of 19 to 35 months receiving complete immunizations, and a low premature death rate.

"The quality of care provided by Vermont's physicians and other health care providers is a significant reason for the State's top ranking," said Paul Harrington, Executive Vice President of the Vermont Medical Society. "Vermont physicians work extremely hard to make sure all their patients have the best possible health care, despite the fact that reimbursement rates here tend to be lower than other parts of the country. I think it really speaks to the dedication and skills of Vermont's physician community," he said.

While about 10 percent of Vermont's population is uninsured (the ninth lowest rate in the country), Vermont's physicians do provide a large amount of free care to their patients who lack coverage and cannot afford to pay, noted Glen Neale, M.D., President of the Vermont Medical Society. "Vermont's physicians are very generous with their time, because they realize the importance of everyone having access to good health care," he said. That is also evidenced by the fact that approximately 91 percent of Vermont's physicians participate in the State's Medicaid program, despite reimbursement that is about half of what commercial insurers pay.

The adequacy of prenatal care has been one area where Vermont has seen major improvements, going from 62.6 percent of pregnant women having adequate care in 1990 to 86.4 percent in 2007 (second highest in the nation). Infant mortality has dropped from 9.2 deaths per 1,000 live births in 1990 to 5.3 deaths per 1,000 live births in 2007.

The number of cardiovascular deaths has declined from 409 per 100,000 of population in 1990 to 287.9 per 100,000 in 2007. The number of cancer deaths has shrunk from 209.2 per 100,000 of population in 1990 to 195.4 per 100,000 in 2007.

A number of public health factors have influenced Vermont's steady rise to the top of the rankings, the United Health Foundation said. For example, since 1990 the prevalence of smoking in Vermont has decreased from 30.7 percent to 18 percent of the adult population, and the incidence of infectious disease decreased from 20.3 to 6.4 cases per 100,000 population.

"Vermont's physicians have been working with the Vermont Department of Health and following guidelines for improving public health," Dr. Neale said. "Being ranked the healthiest state in the nation is an indicator that our efforts are paying off."

## SENATOR PATRICK LEAHY'S LEGISLATIVE HEALTH PRIORITIES



As you listen to the national dialogue about pressing issues facing our country, the conversation is dominated by discussion of the war in Iraq and national security. Meanwhile, as gas prices increase and winter sets in, more people are talking about how expensive it is to fuel up their cars and to heat their homes. And after every increase to monthly health insurance premiums or trip to the doctor, we hear from our family, friends, and neighbors about our expensive and broken health care system. Finding solutions to any of these issues is by no means an easy task, but for a long time we as a country have been talking about solving the health care crisis and I know that you feel as invested and committed to progress as I do.

Federal and State health programs such as Medicare and Medicaid, along with community health centers, provide a critical safety net for our elderly and indigent populations. But millions of people are still falling through the cracks. A significant portion of those that are uninsured in America have jobs but cannot afford to purchase insurance through their employers. Though we spend twice as much per person on health care in America as any other country, forty-seven million of our fellow citizens are denied access.

Efforts to provide health care coverage for the uninsured on both the state and national level will only be compounded if we fail to recognize the need to address new trends in the physician workforce. In Vermont and other rural areas we continue to see a shortage of primary care physicians and specialists in anesthesiology, radiology, and other fields. The same trend is true for our nursing workforce and many of our allied health professions. These shortages threaten to impact patient access and care if we do not begin to reverse them.

We are fortunate to have a wonderful quality of life to offer physicians looking to practice in Vermont. Unfortunately, we also have to compete with places that can offer higher compensation. The federal government's downward trend on Medicare reimbursement has served only to further threaten our physician workforce as doctors have had to cover the growing gap between the cost of treating patients and what the government will pay for that care.

As the first session of the 110th Congress wraps up, we are working to stave off a ten percent cut in Medicare reimbursement for 2008. This has regrettably become an annual event. I have consistently supported blocking these cuts and this year have advocated for a two-year fix to the Medicare reimbursement formula. If we are successful in this effort, Congress and CMS should have enough time to implement a plan that provides a better method for reimbursing physicians.

Supporting practicing physicians is important to keeping doctors in Vermont. On the other side of the equation, we must also expand the pipeline for producing new generations of doctors. For our state, this means making significant investments in the University of Vermont College of Medicine and ensuring that it remains one of the top small medical schools in the country. I have worked with the College to secure funds for its continual need of updated facilities and equipment, and am currently working to help the College with new imaging and surgical facilities.

There are multiple other federal programs that I have worked to protect funding for to ensure we have a vibrant medical school in Vermont. Increased NIH funding is essential to the College's work and to providing research opportunities for younger doctors. The Title VII Health Professions Program that funds UVM's AHEC provides continuing education and loan repayment for practicing physicians and health career information to young Vermonters. These are just two examples of how federal programs impact Vermont's physician workforce.

Finally, we must bring our health care system fully into line with the technological advances of the 21st Century. One of the easiest advances to visualize is the progression to an electronic medical record for patients. This hardware and software comes at a significant cost and, as Vermont's hospitals and physicians move towards implementing EMRs, we must provide financial support to ensure that all providers, large and small, are able to adopt this technology. Over the past three years, I have worked to secure federal funds for Vermont Information Technology Leaders, Inc.; these funds would help providers connect with the health information exchange.

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## NEW BILLING REQUIREMENT FOR PHYSICIANS AND HOSPITALS NATIONAL DRUG CODE (NDC) REQUIREMENT

As a result of The Deficit Reduction Act of 2005, state collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers is now a requirement. CMS is mandating that Medicaid start collecting rebates for all physician-administered drugs billed on physician and/or institutional and crossover claims effective with date of service January 1, 2008.

In order to collect the rebate and invoice from the correct manufacturer, Vermont Medicaid will require the 11 digit NDC number, the Unit of Measurement Qualifier Code and the unit quantity to be reported in addition to the HCPCS codes on paper and electronic submission for professional and outpatient claims at the detail level.

This requirement does not apply to state-supplied vaccines or samples, only to drugs purchased by physicians and hospitals and billed to Medicaid.

More specific billing information can be obtained in the Vermont Medicaid Advisory for October 2007 or on the website at: [www.vtmedicaid.com](http://www.vtmedicaid.com).

The OVHA has requested a waiver of this requirement until the end of February from CMS. At this writing, OVHA has not received a reply from CMS. Vermont Medicaid is requesting that providers prepare for this requirement at this time.

## DIABETES EDUCATION RESOURCE

The links on the VDH website are now "live" for PDF's in the 2008 Diabetes Toolkit authored by Janice Waterman and edited by Robin Edelman.

The web address is: <http://healthvermont.gov/prevent/diabetes/diabetes.aspx>

Toolkit sheets are one or two pages in length, and black and white - designed for easy reproduction as needed at the health care site.

These large-print toolkit sheets were developed to supplement "Learning to Live Well with Diabetes", which will also be updated (in its original format with photos and color) in 2008.

### Toolkit topics include:

Blood Pressure and Diabetes  
Move More for Diabetes (Physical Activity)  
How to Prevent or Delay Diabetes  
Carb Counting and Diabetes  
The Facts about Fats  
Sugars and Sugar Substitutes  
Diabetes: Lose a Little Weight....Gain a Lot of Control  
A1C....What's Your Number?

## HOUSE AND SENATE APPROVES MEDICARE/SCHIP LEGISLATION TO STOP 10.1 PERCENT CUT IN PHYSICIAN REIMBURSEMENT UNTIL JUNE 30, 2008, AND EXTEND SCHIP TO MARCH 31, 2009

By a 411-3 vote, the U.S. House of Representatives on December 19th approved legislation (S. 2499) providing a modest six-month Medicare pay increase for physicians and extending funding for the State Children's Health Insurance Program (SCHIP) through March 31, 2009. The Senate approved the measure by unanimous consent on December 18th.

The bill would provide physicians with a 0.5 percent payment increase in their Medicare reimbursement through June 30, 2008, canceling a 10.1 percent cut scheduled to take effect Jan. 1, 2008. Congress will have to address the issue again in mid-2008 to avoid yet another payment cut in the range of 10.1 percent from taking effect July 1, 2008.

While the VMS appreciates Congress' action in passing last minute legislation to prevent the 10.1 percent cut from going in to effect, the final bill stops the cut for only six months and it still falls short of providing an increase that would help physicians keep up with their medical practice costs, which CMS estimated will increase by 1.8 percent in 2008.

During the next six months, the VMS will work with the AMA and other state and specialty societies to strongly urge Congress to break the tradition of short-term interventions and to develop a long-term path for replacing the flawed sustainable growth rate (SGR) payment formula that is a barrier to improving quality and access to care for seniors.

### Summary of S. 2499, the Medicare, Medicaid and SCHIP Extension Act of 2007:

**Increase in Medicare physician payment update** - Replaces the scheduled 10.1% cut to the Medicare physician reimbursement rate in 2008 with a 0.5% increase through June 30, 2008.

**Medicare Physician Quality Reporting Initiative (PQRI)** - Authorizes an additional 1.5% bonus for Medicare Physician Quality Reporting Initiative (PQRI) activities through December 31, 2008.

**Extension of the floor on work geographic adjustment** - Extends for six months the work geographic index (GPCI) floor of 1.0 through June 30, 2008. For Vermont, the GPCI work floor has resulted in a 1.8 percent increase in Medicare reimbursement to physicians.

**Payment for Part B drugs** - Implements HHS OIG recommendation to require CMS to adjust its Average Sales Price (ASP) calculation to use volume-weighted ASPs based on actual sales volume.

**Accommodation of physicians ordered to active duty in the Armed Service** - Extends until June 30, 2008 a provision that permits physicians in the armed services to engage in substitute billing arrangements for longer than 60 days when they are ordered to active duty.

**Treatment of certain hospitals for payment under Medicare** - Extends until September 30, 2008, provisions that have allowed certain hospitals to be eligible for wage index reclassification that were otherwise unable to qualify for administrative wage index reclassification.

**Moratorium on certain payment restrictions** - Imposes a six-month delay on implementation of proposed administrative regulations relating to school-based services and rehabilitation services.

**Extending SCHIP funding through March 31, 2009** - Extends the State Children's Health Insurance Program (SCHIP) through March 31, 2009. Provides adequate funding to states for the purpose of maintaining their current enrollment through that date.

## LEGISLATIVE HEALTH PRIORITIES

*Continued from Page 2*

We have already seen health care be a central issue for both parties on the campaign trail for the 2008 presidential election. That is a good sign as the electorate is clamoring for fresh ideas and, with a closely divided Congress, it will be up to the next President to set the agenda for health care reform. Ultimately, any plan that is put forward should build on the pillars of our current system to ensure universal access to quality, affordable health care coverage.

We are fortunate to have a dedicated workforce of physicians and nurses who put their patients' care above all. Congress and the federal government have an important role in supporting the work of our medical professionals and you can be sure I will continue to advance the health care priorities of Vermonters.

Thank you for this opportunity to contribute to the Vermont Medical Society newsletter.

Sincerely,

*Patrick Leahy*

United States Senator

## BLUE CROSS BLUE SHIELD OF VERMONT SPEEDS UP CREDENTIALING PROCESS

Physicians who wish to join a practitioner network of Blue Cross and Blue Shield of Vermont (BCBSVT) can be credentialed more quickly because of several credentialing process improvements made by the insurer.

Two years ago, it took more than 100 days to enroll a practitioner in one of BCBSVT's networks. The company has since implemented an electronic system and streamlined the review of applications. This has allowed the insurer to eliminate a backlog and cut the turnaround time to as little as 17 days.

"We looked at our process from end to end," to determine where it could be improved, said Sharon Winn, Director of Quality Improvement.

Perhaps the biggest change has been using the standardized credentialing form developed by the Council for Affordable Quality Healthcare (CAQH), a non-profit alliance of health plans, networks and trade associations. Practitioners complete one application that is used by participating health plans and health care organizations.

BCBSVT started to implement the electronic CAQH credentialing application in January 2007, and as of July 1 its use is mandatory, said Kathy Cota, Network Quality Coordinator. The online form has improved processing because applicants must complete all sections before submitting it. Previously, practitioners sometimes submitted incomplete paper forms, she said. BCBSVT then had to spend time gathering the missing information.

BCBSVT also took steps to reduce the amount of time needed to review an application once it's submitted, Cota said. Several manual handoffs were eliminated. The outside vendor that BCBSVT uses to verify information cut the number of days it needed to complete the work. "We pushed them hard and they made a lot of changes to respond to it," said Winn.

Now that BCBSVT uses an electronic system, files are sent each day from the verification vendor, rather than being mailed once a week.

Receiving final approval takes less time as well, she said. Previously all files went through a credentialing committee. BCBSVT changed its process so that applications that meet its standards can be approved by a medical director without going through the committee.

Over time, BCBSVT has increased the frequency of medical director review and sign off. Meetings between a medical director and the credentialing staff now occur almost daily.

The result has been a steady improvement in turnaround time, said Winn, with the number of days needed to process an application dropping from 64 in April to 17 in August. Winn also reminds physicians that the enrollment process cannot be completed until they sign a contract.

BCBSVT will continue to monitor cycle times, Winn said, but if it stays between 17 and 25 days "that will be a real success story."

## TOOLS FOR COLLECTING DATA ON OVERWEIGHT PATIENTS

By Carol Vassar, MD

The prevalence of overweight patients is still rising. Between 1998 and 2006, the prevalence of BMI>30 in the Vermont population doubled. Prevalence figures for each state from 1985 to 2006, are available as a power point download on the CDC web site <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm>. These data are from the BRFSS surveys conducted by the states at considerable expense and are known to underestimate the problem due to being self reported height and weight. The NHANES data are actual measurements but cost millions of dollars. We need a reliable but inexpensive way of collecting prevalence data.

We know that overweight is a very serious problem, but we lack detailed information about it. Here are some health consequences, as presented by the U.S. Department of Health and Human Services:

- Heart disease risk goes up as BMI goes above 25
- Diabetes risk doubles with as little as an 11-18 pound weight gain.  
*[This is misleading. The increase is tiny at this point though it becomes very significant with greater weight gain.]*
- Hypertension is twice as common with BMI>30
- A woman who gains 20 pounds between age 18 and midlife doubles her risk of post menopausal breast cancer  
*[which is very high to begin with so this is a major risk]*
- Sleep apnea is more common among those who are overweight.
- For every 2 pound weight gain, the risk of arthritis rises 9-13%.  
*([http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact\\_consequences.htm](http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.htm))*

We need to know and be able to follow the prevalence of overweight to be able to appreciate the extent of the problem and to be able to assess our progress or lack thereof in dealing with it. We need to know the nature and the degree of the risks of overweight to know how we should approach each individual patient. We need to know the long term risks and benefits of bariatric surgery to know when to use it.

We need to know the costs to know how much to invest in preventing the problem and to give us greater incentive to do something about it, as individuals, as physicians, as a society. All of this information can be acquired by having physicians use the BMI codes at least once a year for each patient they see.

### How it would work

The first time a patient is seen in any calendar year, the ICD-9-CM code corresponding to the patient's BMI would be included as a supporting (second diagnosis) code in billing for that visit. Any time the patient is seen for a general medical consult or a physical exam or a comprehensive exam, the BMI code would be included as appropriate to the evaluation of a patient for that level of service.

When the BMI code is the only diagnosis code listed, then the physician is reimbursed at the 22911 or 22912 level of service depending on whether the supporting staff or the physician counseled the patient at that visit. When two or more ICD codes are listed, the physician would be reimbursed for whatever level of service the insurer would otherwise cover for the initial diagnosis code plus a supporting ICD code listed on the billing form. I would also like to see the BMI codes accepted as adequate for reimbursement at least four times a year for a 22913 when the BMI is over 30.

If you would like more information, please email me at [cavassar@comcast.net](mailto:cavassar@comcast.net)

### ICD-9-CM codes for BMI's

<http://icd9cm.chrisendres.com/2007/index.php?action=child&recordid=11174>

#### BODY MASS INDEX (V85)

*Note: these BMI adult codes are for use for persons over 20 years old*

V85.0	BMI	less than 19
V85.1	BMI	between 19-24
V85.21	BMI	25.0-25.9
V85.22	BMI	26.0-26.9
V85.23	BMI	27.0-27.9
V85.24	BMI	28.0-28.9
V85.25	BMI	29.0-29.9
V85.30	BMI	30.0-30.9
V85.31	BMI	31.0-31.9
V85.32	BMI	32.0-32.9
V85.33	BMI	33.0-33.9
V85.34	BMI	34.0-34.9
V85.35	BMI	35.0-35.9
V85.36	BMI	36.0-36.9
V85.37	BMI	37.0-37.9
V85.38	BMI	38.0-38.9
V85.39	BMI	39.0-39.9
V85.4	BMI	40 and over

## TOOLKIT AVAILABLE FOR PROMOTING HEALTHIER WEIGHT

The University of Vermont College of Medicine's Area Health Education Centers program and the Vermont Department of Health's Fit & Healthy Vermonters program have teamed up to produce a toolkit that physicians can use to promote healthier weight in adult primary care.

The kit contains a Weight and Health Profile pad. On the pad clinicians can document the patient's Body Mass Index (BMI) and associated health risk level, waist circumference, other health conditions and risk factors, and the patient's readiness to take steps to improve his or her health.

Also on the pad is a check-off area for recommended physical activity goals, nutrition goals, and weight goals. On the back is a list of national and state resources. The no-carbon required pads have two sheets, so one copy can be given to the patient while the other is kept for the medical record.

The kit educates clinicians on how they can promote healthier weight, and contains an algorithm for use in patient encounters. A list of resources for clinicians is also included.

The publication covers steps to prepare the physician office for promoting healthier weight, and a set of V codes for billing Medicare by BMI.

Additional tools in the kit include a BMI chart, a BMI wheel, and a poster that explains to patients how they can control their food and drink portions.

To receive a toolkit, contact the Vermont Area Health Education Centers at 656-2179 or email [ahec@uvm.edu](mailto:ahec@uvm.edu).

## VMS MEMBERS CONTRIBUTE

We sincerely thank all of those who have contributed to the VMS ERF and the VMS PAC. Your contributions have helped to shape the future of healthcare and medicine in the State of Vermont.

The VMS sponsors a nonprofit charitable organization that supports educational and research activities in the field of health. The foundation provides grants to deserving medical students at the University of Vermont College of Medicine. The intent of such grants is to provide an incentive for candidates to pursue a career in medicine and to provide motivation for graduates to practice in Vermont. All contributions to the foundation are tax deductible.

The VMS also has a Political Action Committee (PAC). The PAC makes financial contributions to candidates for the Vermont General Assembly and statewide offices who understand the challenges physicians face in caring for Vermont's citizens. Candidates are questioned about their positions on issues that are important to VMS members, such as health care reform and medical liability reform. Only the candidates who express support for the VMS's goals receive contributions.

For more information on contributing, contact

Colleen Magne at 802-223-7898 or [cmagne@vtmd.org](mailto:cmagne@vtmd.org)



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