Community Health Centers

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Hello, my name is Erika Brown and I am the Director of Patient Accounts for the Community Health Centers, the Federally Qualified Health Center serving Chittenden and southern Grand Isle counties.

I'd like to thank the committee members for being here today to hear more about our important work, especially related to processing claims.

As a quick background, the Community Health Centers has been around since 1971, understanding and addressing the needs of our community members regardless of financial status or life circumstance.

We currently care for 32,000 patients, providing medical, dental, counseling and psychiatry services – among many other specialized safety net programs like our homeless healthcare program.

On Average we have about 135K encounters per year.
In a years' time, we submit an average of 178K primary claims alone per year. BCBS being our largest Commercial payer.

Cotiviti edits/denials went into effect in Dec of 2022. Since these edits have been implemented, we have had a significant increase of up to 33% in claim denials for this payer. These claim denials were further complicated to work since the reason for denial reported falls into general categories which could account for any one of many denial reasons. After coder reviewed many of these denials and saw no issue with coding, our next step was to contact the call center.

The BCBS Call center has had a 2+ hour hold time for the last couple of years. The inability to be able to reach the call center has further delayed any insight to resolve unpaid claims. We were then given an email address customerservice@bcbsvt.com for BCBS VT and Bluecard@bcbsvt.com for out of state BC as an alternative. This resulted in either unanswered emails or after 30 days we would receive a message stating they could not open the email. They were sent encrypted since there was private patient information however since the BCBS team was not opening these emails timely they would expire which required us to resend emails. We have had to resent emails or more times and still have no responses from many of these. In November 2023 BCBS communicated an email issue with the above email address and requested emails be sent to HPPCEMAIL@bcbsvt.com going forward for any BCBS VT inquiries.

In Nov of 2023 BCBS, primary care groups as well as others met to discuss some of these issues. At that time, we were given another email address to send chart notes to for claims denied (COTIVITI denials) Paymentintegrityexternal@bcbsvt.com. Since November 2023 we have only received 1 response and have not received payment on said claims. The process is that after the emails are sent, we should receive a confirmation email and if not received within 5 dates, we have to reach out again to the same email to let them know that no confirmation email was received. We are not receiving confirmation emails at this time.

It can take up to 30 days for the chart notes to be reviewed when it's a BCBS VT plan and up to 60 days for an out of state BC plan. If denied for non-payment, we are supposed to get feedback however have only received one feedback email to date. If denied, we can submit for another review substantiating the rationale as to why this met coding guidelines for payment. Overall, this delay in payment also affects patients, especially those who have a deductible plan and will not get a final bill until this process is compete and the payer sends the EOB noting the patient balance.

Some of the denial issues are noted below.

The 25 Modifier: Coding guidelines state that this modifier should be appended to a CPT code to report an Evaluation and Management (E/M) service on a day when another service was provided to the patient by the same physician or other qualified health care professional. This is needed for the payer to consider payment for both services provided. Both services are no longer paid when at time of initial claim processing.

We do our best to give comprehensive care to patients and part of that is recognizing social determinants such as transportation. Many of these patients struggle to get appointments and time off of work, so it's imperative if both services can be rendered in one day that our providers do so. In a climate where access to care is already and issue, we do our best to meet patient's needs. Delays in payments for any visits where two services are rendered and warrant a 25 modifier cause significant payment delays for our health center.

Other issues are requiring redundant information that other payers don't require on claims for payment. BCBS requires extra documentation that should not be needed and is not needed for any other payer with the current coding. This is pertaining to laterality of a given service or procedure.

In Summary, these changes in claim processing have had a negative impact in not receiving payments for services we rendered and or has delayed payments significantly, increased administrative burden for all coding and billing, and has delays bills to patients. We have lost staff in the billing dept to work at COSTCO due to the stress of payments obstacles, delays and insurance processes that are not consistent, sustainable, or often are not working.

We continue to care for our patients however in a climate where margins are already slim, this additional work to gain payment for services rendered is unfavorable for all. The payer who has to generate and send weekly detailed denial reports to each primary care office and has to complete manual review, patients for access of care and delayed bills and the health center to carry such a large administrative task and wait up to 90 days or more for payment.

Thank you for your time. Please feel free to reach out to me any time with questions.

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