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Claims Edit Testimony
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CPT Codes
Current Procedural Terminology codes, or CPT codes, offer doctors and health care professionals a uniform language for coding medical services to streamline reporting, increase accuracy and facilitate payment.

We understand the challenges faced by provider offices - medical coding can be compared to learning a new language, requiring significant training for coders to master. Last December, we collaborated with the Vermont Medical Society to conduct a training session focused on Modifiers 25 and 59. The recorded webinar is accessible as a resource on the Blue Cross VT provider website (https://www.bluecrossvt.org/providers/provider-forms-resources under the "Coding" link, passcode **4%FxdHNc**). Additionally, our provider relations team is ready to assist and support practices as needed. Health insurance plans have a financial obligation to our members to review provider claims for accuracy, correct billing for the care provided, and identify cases of fraud, waste, and abuse.[1] [2] Both members and employers place trust in their health plans to make sure their healthcare bills are correct.

Claim Edits
Claims edits are a widely used method to review claims, ensuring accuracy and consistency in coding. To illustrate, think of receiving a detailed bill at a restaurant that lists all charges, such as service fees and taxes, resulting in the total amount owed. This transparency is crucial in healthcare for patients, much like it is for customers in a store or restaurant. Like checking your household bills, claims edits scrutinize and adjust claims to prevent overpayment or incorrect reimbursement for services.

At Blue Cross VT, we rely on coding standards established by external bodies like the American Medical

[1] **False Claims Act, 31 U**.S.C. **§ 3729:** The Act creates civil liability for offenses related to certain acts, including knowingly presenting a false or fraudulent claim to the government for payment, and making a record or statement that is material to the false or fraudulent claim. Note, "knowingly" includes not only actual knowledge, **but also deliberate ignorance or reckless disregard for the truth or falsity of information**. This is a major reason why we have a Fraud, Waste & Abuse program. If we simply go on faith that Vermont providers would not knowingly or unknowingly be submitting fraudulent claims, Vermont rate payers would be liable for any FWA that we passed over or on to the government. Liability includes $11,000 per claim plus THREE times the amount of damages the government sustains because of the false claim. Note that individuals can also bring suits as well on behalf of the government if they suspect fraud.

[2] **Vermont False Claims Act, 32 V.S.A. § 631**: makes it unlawful for any person to: (1) knowingly present or cause to be presented a false or fraudulent claim for payment or approval; (2) knowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim; (3) knowingly present or cause to be presented a claim that violates Vermont and federal laws against improper referrals and kickbacks; (4) knowingly make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money to the State; (5) knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money to the State; (6) fail to disclose an inadvertent false claim or overpayment within 120 days of discovering the error; (7)conspire to commit a violation of the VFCA.

Association (AMA), Centers for Medicare and Medicaid Services (CMS), and specialty medical organizations. Blue Cross VT does not adopt edits that are unique to our health plan.

The goal of this process is to ensure that claims use accurate codes that properly represent the services provided. We always expect comprehensive medical documentation to support each claim, akin to verifying items in your shopping cart against the store bill.

The purposes of our claims edits are to ensure consistency in payment across all providers, guarantee appropriate charges for our members, maintain consistent coding among providers, and level the playing field for our members and providers with other health insurance plans. Moreover, claims edits help identify mistakes, serious coding errors, and inconsistencies. All payers, including CMS for Medicare and Medicaid, utilize claim edits or conduct claim audits.

Claims edits undergo periodic review and updates. On January 13, 2023, Blue Cross VT implemented several changes to these edits. These alterations were made following 18 V.S.A. § 9418a, which included inviting the DFR to review the proposed changes and providing a 90-day advance notice to all of our providers. Each practice is responsible for adhering to national coding standards set by CMS, the AMA, and their specialty organizations.

Prior to 2023, adjustments for inappropriate use of Modifiers 25 and 59 were made during post-payment provider audits. As of January 2023, we began reviewing modifiers 25 and 59 to submitted claims pre-payment. This means that our policy has not changed for these codes, but our approach to enforcement is more immediate.

Modifiers 25 and 59 allow providers to bill for additional services when a patient presents with an unrelated second health issue requiring substantial additional work – such as requesting labs, referring to specialists, or additional treatment unrelated to other care they are receiving in the same visit. Addressing a separate significant health issue can increase the workload for a provider, and rightly increases the cost of the appointment.

I'd like to give an example of billing both 25 and 59 modifiers:

- Regarding modifier 25: Suppose I visited a chiropractor for neck pain. For the first visit, the chiropractor billed for an initial evaluation. Subsequent visits for my neck pain were billed as procedure visits for my neck adjustments. If, during the fourth visit, I arrived with new back pain unrelated to the neck issue, the chiropractor would assess this new pain. In addition to billing for adjusting my neck, they would use modifier 25 to bill separately for evaluating and managing my new back pain. However, some chiropractors incorrectly used modifier 25 for every visit, even for simple adjustments of existing conditions.
- An example of a 59 modifier would be if a surgeon performs an ACL repair on a patient's knee, the code for the surgery includes the actual repair of the ligament—they would not bill a separate code for this. However, the surgeon could bill a 59 modifier if there were a separate procedure at a different site, such as an elbow ligament repair.

Post-service audits are not a good method for enforcing coding compliance because it is so long after the fact. It does not protect the patient, misses the opportunity for provider education, and is unevenly applied only to the practice being audited. We are only able to audit a couple of practices each year, and the last practice we audited found that 25% of modifier 25 codes were billed incorrectly. With this new process, we are able to audit all providers.

It may be helpful to the Committee to know some data we have to show the impact of the Modifier 25 and 59 codes:

- Blue Cross receives over 9 million lines of claims accounting for $1.8 billion in claims paid.
- About 7% of claims have a Modifier 25 or 59.
- Of these, the Claims Edits applied to 5.4% of claims submitted with a Modifier 25 or 59.
- Providers have an opportunity to submit medical records to support their modifier billing.
- Overall, 8% of the claim edits for modifiers 25 and 59 are being overturned due to medical record resubmissions.

Once we have a year of complete data, we will gold-card certain providers for the use of the 25 and 59 modifiers if the Cotiviti record reviews suggest a practice is using these codes correctly.
In summary, Blue Cross VT believes that applying claims edits to modifiers 25 and 59 is necessary to reduce member costs. We are obligated to review and adjudicate claims appropriately. Vermonters are drowning in healthcare costs that they cannot afford, and we cannot continue to pay for services that were not provided. Thank you for your time today.