BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

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January 23, 2024

Representative Houghton, Chair
Representative McFaun, Vice Chair
Representative Black, Ranking Member
Representative Berbeco
Representative Carpenter
Representative Cina
Representative Cordes
Representative Demar
Representative Farlice-Rubio
Representative Goldman
Representative Peterson

Dear Members of the House Health Care Committee,

Below are the answers to the questions from your letter dated January 15, 2024. Claims editing is a detailed process and our answers may benefit from additional explanation if you have questions.

1. Please describe how you define a claim edit.

Claims editing is a step in the claims payment cycle verifying that submitted bills reflect the services that were received. This protects the patient from overpaying for services and catching billing mistakes.

An “edit” refers to the practice of verifying that one or more rule recommendations, made to Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes included in a claim, are being applied correctly. These can include National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits; medically unlikely edits (MUEs); add on code (AOC) edits, uniform billing editor (UBE), and NCCI program edits such as invalid diagnosis codes, invalid diagnosis code pairing, diagnosis and age conflict, and Medicare secondary payer alerts, among others.

There may also be history editing, which checks for potential overbilling and split billing (i.e., submitting two separate claims to potentially bypass edits), bundled services (an example of a bundled service by CMS standards is collecting a blood specimen (CPT 36416) and the evaluation and management office visit; the collection of a specimen is bundled/included into the E/M service), or billing more units that are allowed in the CMS MUE edits, per NCCI’s guidelines. The system checks claims that were already submitted based on data points to avoid overpayments. This history review helps to ensure continuity and accuracy, and to prevent double-billing the patient. A claim edit may also include any manual review of a claim, such as for a high-dollar claim. Claim edits help identify mistakes, serious coding errors, and inconsistencies. All payers, including CMS for Medicare and Medicaid, utilize claim edits or conduct claim audits.

2. Which codes are subject to your claim edit policies?

All American Medical Association (AMA), CPT®/HCPCS, ICD-10 codes and code combinations are subject to claims editing policies.

3. How often are changes to these policies made?

Editing updates are usually in conjunction with Center for Medicaid and Medicare Services (CMS) changes that are generally quarterly.

4. How many other payers in Vermont and nationally apply the same edits in the same manner as your organization?

- Four health plans in Vermont apply these same coding edits using Cotiviti as a vendor (three in addition to Blue Cross VT)
- 11 health plans in New York apply these coding edits
- 42 health plans nationally

5. What data informed the decision to choose this auditing model? What criteria and process was used to select Cotiviti as the analytics company? What tools are BCBS using to assess its efficacy?

Blue Cross VT implemented a second claims editing program in January 2023 because of new recommendations from CMS, as well as a new Blue Cross and Blue Shield Association requirement for the implementation of a "second pass" editing system.

Several vendors were considered for the second pass program before the decision was made to engage Cotiviti. Blue Cross VT had an existing contract with the organization, and the necessary system configurations already were in place to support the implementation. Additionally, 92% of Blue Cross and Blue Shield plans work with Cotiviti. Of those plans, 10 use similar pre-pay and post-pay edits across 45 million members.

These claims edit processes use both Registered Nurses with a Certified Professional Coder (CPC) certification, and certified professional coders to review the validity of the edits and the efficacy on Vermont claims.

6. Please provide any data based on Vermont providers' use of the codes subject to your claim edit policy that was the basis for determining that these edits were necessary.

An analysis was performed to identify savings using 2021 Blue Cross VT's claims experience. The analysis looked at claims in compliance with payment policies and on coding validation (bases on CMS, AMA, HCPCS, and ICD-10). Estimated annual savings for rate payers and self-funded clients exceeded $12 million, demonstrating that incorrect coding was happening in Vermont across all providers. In the first year of implementation, which spanned the 2023 plan year, these edits resulted in $34.3 in recoveries, which has a direct impact on lower premiums for teachers, municipal, state and federal employees, non-profits, small and large businesses, and individuals.

7. Who in your organization decides that a claim edit is necessary?

All proposed process changes, including claim edits, go through a lengthy process of internal review and approval before implementation. Certified coders review the proposals in detail, make recommendations to a larger internal committee, before a final review and ultimate approval is made by the Vice President of Administration and the Chief Medical Officer.

8. Please describe the role of contracted entities in implementing these edits.

Blue Cross VT contracts with two vendors to implement coding edits that we determine are appropriate. The Cotiviti system has a coding validation process that uses pause and pay functionality to ensure proper modifier use. The process uses a platform that deploys advanced analytics, contextual claim edit review, and review by Cotiviti's Registered Nurses with a Certified Professional Coder certification and reconsideration by management staff. Blue Cross VT's coders and nurses with CPC certification support the implementation and provide another level of review that is local.

9. What is the notification process when implementing a new claim edit? Do you provide coding education prior to implementation?

After claim edit decisions are finalized internally with recommendations for new or revised edits, Blue Cross VT notifies the Department of Financial Regulation (according to Rule 09-03) 90 days prior to implementation. Providers are notified at least 60 days in advance of implementation through email and posting to the recent news and correspondence area of the provider web page. The notice provides a high-level detail of edit changes and provides a link to the payment policy for full details. For example, the Claims Edit Payment Policy reflects changes to coding edits in red font, with the effective date noted.

Typically, providers and practices are responsible for correct coding and compliance with national standards and requirements. In response to questions about Modifiers 25 and 59, Blue Cross VT and the Vermont Medical Society co-hosted an educational webinar taught by independent coding specialists. The webinar seemed to be well received by the provider community. Going forward, we plan to offer more education opportunities for providers.

10. Since January 2022 what practice improvements have you made based on feedback from providers? What strategy is in place to determine that practice improvements are needed?

Since January 2023, Blue Cross VT has made a number of process improvements based on provider feedback and concerns:

- For each practice, we provide a spreadsheet detailing the claims under review with additional information about the reasons for denial.
- Our provider relations team meets one-on-one with practices who raised concerns to review denied claims and support the reconsideration process.
- Additional information on both Modifiers 25 and 59 was added to our provider support pages.

- Practice-specific reviews were conducted to determine if particular types of services were impacted negatively by the new edits.
- Providers with low utilization of the modifiers 25/59 have been removed from the edit since its inception (about 200).
- Blue Cross VT hosted and participated in a meeting attended by multiple providers and DFR to talk through issues and discuss better approaches for implementation in the future.
- Blue Cross VT hosted an educational Webinar on Modifiers 25 and 59 coding.

11. Please walk us through the steps of a claim subject to your policy and the timeframes between each step, including any levels of appeal, the timeframe between each level of appeal and the timeframe to final adjudication. Be specific on each step including how providers are required to communicate through each step.

When Blue Cross VT receives a reconsideration or appeal request from a provider the following steps are taken for review:

- Respond to the provider indicating receipt of the request for review of the claim and confirm that the claim has been denied within 24 business hours.
- A certified coder or a registered nurse with a Certified Professional Coder certification reviews the additional documentation submitted to determine if the notes from the visit support the billing of the code or modifier.
- If approved, the claim is adjusted.
- If denied, a letter is sent to the provider indicating that the claim review has been denied, why it was denied, and the guidelines as to what was reviewed.
- Our goal is to review records within 10 days. The total review process can take up to 60 days to complete, with an average of 47 days.

12. What data is provided to the provider when a claim is denied?

When a claim is denied, Blue Cross VT notifies the provider via email including the reason for the denial. Information is also provided on how to appeal a denial and what documentation is required for additional review.

Example of claim denial language:

> We have reviewed claim number XXX and have determined that we have upheld the denial.
>
> The following information supports the decision to uphold:
>
> *According to NCCI: The CPT Manual defines modifier 25 as a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.*
>
> *Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other*

services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s). Modifier 25 may be appended to E&M services reported with minor surgical procedures (with global periods of 000 or 010 days) or procedures not covered by Global Surgery Rules (with a global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intraprocedure, and post procedure work inherent in the procedure, the provider/supplier shall not report an E&M service for this work. Furthermore, Medicare Global Surgery Rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure regardless of whether the patient is a new or established patient.

According to the documentation, the patient presented for knee injection. It does not support that a separate and significant service was provided in addition to the pre/intra/and post-procedure work associated with the decision to perform the procedure.

If you have additional medical documentation not originally supplied, you have the right to file a second level review within 60 days of receipt of this letter. Your second level review can be submitted to PaymentIntegrityExternal@bcbsvt.com.

13. Please provide the policy directed timeframe for payment on claims and appeals. Provide data that these timelines are being met or that interest is being paid to the providers.

In the event the claim is approved for payment, prompt pay interest is applied as required by statute. There are 29,260 coding validation impacted claim lines. Of those 4,680 have been adjusted. Of the 4,680 claim lines, 2,213 have paid interest totaling just over $136,000.

14. Since this claims edit policy change, provide the data regarding how many claim edits were paid, denied or appealed at each stage of your policy. How many were overturned and paid? How many are still in limbo? Provide the data by claim edit code, provider type and month. Include the counts and dollars.

See excel document for data.

15. How many claims have been denied with reason code MA63. Provide by provider type.

Timeframe: 1/1/2023 – 11/30/2023

- 20,303 claim lines had a modifier 25 or 59
- 5,559 were denied

See excel document for data by specialty.

16. Please describe who (expertise/qualifications) makes the determination regarding payment at each stage of your policy.

National guidelines for correct coding are reviewed by both Blue Cross VT and our payment integrity vendors. A significant cohort of experts review these guidelines to ensure appropriateness and applicability to Vermont statutes and rules and alignment with Blue Cross VT payment policies. Experts for guideline review include physicians, pharmacists, dentists, nurses, and professional coders.

The guidelines for modifiers 25/ 59 include:

- National Correct Coding Initiative (NCCI)
- CMS Claims Processing Manuals
- Centers for Medicare & Medicaid Services
- Current Procedural Terminology (CPT) and Coding with Modifiers manuals
- American Medical Association

After the policies are enabled, the administration is performed both in an automated and manual manner. Next, to administer these correct coding guidelines, the claims process through an advanced claims engine. Some of these claims are automated determinations which pay the modifiers as designated and do not require further review.

For modifier 25/59 situations that undergo manual review, these claims are determined by registered nurses with a Certified Professional Coder certification.,

17. Please outline the expense to your organization of using a contractor and the internal staff time and expense needed to implement the edits. Since the modifier 25 and 59 policy has been active for a year, please compare the costs notated above specific to these claim edits and provide the same data for the 2022 year.

When contracting with a vendor, we review the contractual rate for their services. This is a negotiated amount based on our membership lives and claim volumes. There is not a comparison to 2022 as this editing for our entire member population was not in place for 2022.

18. Please describe any savings, with details, attributed to implementing your current claim edit policies. Include the premium cost savings for each plan level you offer on Vermont Health Connect.

For recovery year 2023, overall savings across all groups from all claims edits equal $55.95 million. For all Cotiviti edits in all lines of business, there were $34.3 million in recoveries, approximately $6.2 of the savings is from edits that require additional documentation. This has a direct impact on lower premiums for teachers, municipal, state and federal employees, non-profits, small and large businesses, and individuals.

Blue Cross VT implements programs and invests in technology to ensure our members pay the appropriate cost for their health care and ensure that they are only charged for the services they receive. We cannot project specific future savings for any particular program in our rate filings. We instead assume that savings will grow with medical trend, which in the 2024 QHP filings resulted in an implicit growth assumption of 18.1% in the absolute value of recoveries, or savings. We assume this growth will be achieved through a combination of new or existing programs. Providers adjust to new programs and payment policies, making the percentage of claims recovered stable while the sentinel effect of these programs has a continued and significant impact on the overall cost of care for Vermonters.

Once these programs in the experience period are used in rate filings, their impacts will be reflected in premiums, assuming no mandated changes occur. As of mid-January, the QHP lines of business saved about $4.5 million in claims cost through Cotiviti edits for calendar year 2023. These savings, assuming they are allowed to continue, will be reflected in the development of the 2025 Qualified Health Plan rates and the starting point of the analysis will be $4.5 million lower than if Blue Cross VT has not implemented these edits. Due to the ACA rating rules, we do not have plan level specific adjustment for market-wide expected changes in claims costs. Each plan level offered on Vermont Health Connect benefits proportionally to all reductions in claims costs due to claims edits based on their expected paid-to-allowed ratio and other allowable rating differences under the ACA.

19. Please provide the citation referencing the figure nationally that 35% of coding is inaccurate.

Department of Health and Human Services, Office of Inspector General, Use of Modifier 25, November, 2005, OEI-07-03-00470

> “The Office of Inspector General (OIG) randomly selected 450 claims billed in calendar year 2002 using modifier 25 for medical review. OIG requested from the appropriate providers all medical records for services provided to the beneficiary on the date of service listed on the sampled claim.”
>
> “Findings: In 2002, Medicare should not have allowed payments for 35 percent of claims for E/M services billed using modifier 25. These claims totaled $538 million in improper payments that Medicare and/or beneficiaries made. The payments were improper because the services were deemed (1) noncovered because they did not meet the requirements for use of modifier 25 or (2) undocumented due to failure to meet basic Medicare documentation requirements under section 1833(e) of the Social Security Act (the Act). These claims were distributed across strata, provider specialty types, and the Medicare carriers that allowed the claims.”

Dr. Weigel advised, “We are only able to audit a couple of practices each year, and the last [Vermont] practice we audited found that 25% of modifier 25 codes were billed incorrectly. With this new process, we are able to audit all providers.”

This Vermont practice was audited, and, while their documentation was clear and the notes well organized, 25% of the time the E/M codes were not supported by the records provided. We did an educational audit but the extrapolated overpayment to this practice was $74,614.25 at the time based on probe sample auditing.

20. Please provide in dollars and by year actual fraud losses in Vermont due to incorrect coding since 2021.

Blue Cross VT has a financial and statutory obligation to our members to review provider claims for accuracy, correct billing for the care provided, and identify cases of Fraud, Waste, and Abuse (FWA). Losses due to the FWA category:

- 2021: $30.2 million
- 2022: $32.8 million

Blue Cross VT is responsible for ensuring compliance with the False Claims Act, 31 U.S.C. § 3729 that includes 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 and Abuse (FWA) program. Vermont providers may not knowingly but could be unknowingly submitting fraudulent claims, Vermont rate payers would be liable for any FWA that Blue Cross VT pays on behalf of our government customers.

Liability, for which Blue Cross is responsible, 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.

The Vermont False Claims Act, 32 V.S.A. § 631 has similar goals in curbing Fraud, Waste and Abuse.

21. What is the average hold time, directly related to appeals, for a provider seeking assistance through customer service? What do you deem an acceptable response time?

The average hold time for a provider to reach customer service is 17:05. Like all Vermont employers, Blue Cross VT was impacted by workforce issues that was spurred by the pandemic. Blue Cross VT continues to recruit and retain Vermont-based customer service employees to serve our members, customers, and provider community to improve wait times in our call center.

Sincerely,

Sara Teachout
Corporate Director, Government and Media Relations