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STATE OF VERMONT
HOUSE OF REPRESENTATIVES

January 15, 2024

Rebecca Cobans
Government and Media Relations
Blue Cross and Blue Shield of Vermont

Dear Rebecca,

Thank you for Dr. Tom Weigel's testimony last week regarding Blue Cross and Blue Shield claims edits process. As discussed at the end of the testimony, below are the questions we would like written answers to for future conversations.

We look forward to receiving the answers by the end of business Tuesday January, 23rd, 2024 and to meeting again soon.

Sincerely,

Rep. Lori Houghton
Chair, House Health Care Committee

Questions:

1. Please describe how you define a claim edit.
2. Which codes are subject to your claim edit policies?
3. How often are changes to these policies made?
4. How many other payers in Vermont and nationally apply the same edits in the same manner as your organization?
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?
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.
7. Who in your organization decides that a claim edit is necessary?
8. Please describe the role of contracted entities in implementing these edits.
9. What is the notification process when implementing a new claim edit? Do you provide coding education prior to implementation?
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?

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.
12. What data is provided to the provider when a claim is denied?
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.
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.
15. How many claims have been denied with reason code MA63. Provide by provider type.
16. Please describe who (expertise/qualifications) makes the determination regarding payment at each stage of your policy.
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.
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.
19. Please provide the citation referencing the figure nationally that 25% of coding is inaccurate.
20. Please provide in dollars and by year actual fraud losses in Vermont due to incorrect coding since 2021.
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?