Claims Edit Testimony
Blue Cross and Blue Shield of Vermont
April 3, 2024

Introduction

My name is Andrew Garland, I'm the Vice President of Client Relations & External Affairs. I've been in this position for almost 10 years and working in health care since 1998, most of that time with Blue Cross VT. I've spent a considerable portion of my career working with providers, in positions including Director of Provider Contracting, Corporate Director of Network and Provider Affairs, and as the Vice President for Enterprise Network Strategy and Payment Reform for MVP Healthcare. As part of that work, I've participated in several legislative workgroups including the fair contracting standards workgroup in and the claims edit standards workgroup.

Claims Edits

I am here to talk about Section 2 of the bill that would have a significant impact on costs for Vermonters. Before I do that, I'd like to make an ask of the committee: please be deliberate and fully informed about the impact of the changes you are considering. When it comes to the cost of healthcare there is no room for error. Commercial clients and members bear an outsized portion of the healthcare costs in Vermont and they are struggling to carry the burden.

The changes this bill contemplates will prevent Blue Cross VT and other payers from applying many of the necessary "checks and corrections" we do to claims prior to processing and paying the bills. This process is a basic financial control.

Briefly, I'd like to take a step back and first talk about CPT (or Current Procedural Terminology) codes. There are over 11,600 CPT codes. These offer healthcare professionals and payers a uniform language for coding medical services to streamline reporting, increase accuracy and facilitate payment. CPT codes are developed and overseen by the American Medical Association. Along with these CPT codes are just over 69,000 ICD-10 codes that communicate diagnosis information, and about a thousand HCPCS codes. These code sets also maintained by CMS. The point being that there are over 80,000 codes in play, and because these codes can and usually are billed in combination, there billions, perhaps trillions of permutations. Even the largest, and most sophisticated healthcare providers can and do make mistakes in the face of this complexity.

Health insurance plans have a financial obligation to our members to review provider claims for accuracy, and correct billing for the care provided. Claims edits identify errors, over-charges and more severe cases of fraud, waste, and abuse. Both members and employers trust and expect their health plan to make sure their healthcare bills are correct.

Blue Cross VT processes over 9 million lines of claims code annually from all types of providers here in Vermont, across the country, and internationally. Blue Cross VT would be irresponsible and failing to meet a basic obligation to our customers if we did not review those billed claims. No legitimate business and no household simply pays every bill that comes in the door without reviewing it to ensure that it's an accurate.

While claims edits are only applied to small portion of the claims processed, they save millions of dollars by identifying errors in the over $1.3 billion in claims Blue Cross VT pays annually for our members and customers.

An example of how a claims edit works: Let's imagine that you order a prix fixe meal at a restaurant—an appetizer, a salad an entrée, desert all for a single price. If the bill came and you were charged the prix fixe amount but also billed separately for the salad and the desert, it would be an overcharge because it was supposed to come with the meal. You would insist that the charge for the salad and desert be removed, and you only pay the prix fixe . That's a simple example of how a claims edit works.

Here are some medical examples:

- Multiple code re-bundling: identifies claims containing two or more procedure codes used to report a single service when a more comprehensive procedure code is available. (AMA edit)
- Procedures or services received with a secondary diagnosis code as the principal or primary diagnosis. ICD-10 requires providers to bill in accordance with their manual, which indicates when a diagnosis can be only billed as secondary. If this were to pass, this would be eliminated. (ICD-10 edit)
- Repeat billing for the same procedure: When I started in provider contracting, hospitals and out of state surgery centers would routinely bill (and expect to be paid) two or even three times for the same colonoscopy. Hard to believe, but it's true. The provider would perform a diagnostic colonoscopy and in the course of the procedure discover and remove a polyp, and discover a lesion and remove it. This encounter would then be billed to Blue Cross VT as three colonoscopies: a diagnostic colonoscopy; a colonoscopy with polyp removal; and a diagnostic with removal of a lesion. The second and third colonoscopies would be billed with a 55 modifier—separate and distinct. Perhaps you think I'm exaggerating, but I'm not. I sat across the table from hospital administrators who tried to convince me that our members should pay for the same procedure three times.

H.766 Section 2 Claims Edits

There are several distinct parts of the Claims Edits section of this bill:

- the overall rules a health plan must follow for which claims edits we may implement;
- the process for adopting new claims edits; and

- the last is specific to prepayment coding validation edit review – this is when a payer asks for medical documentation prior to paying a health care claim as was widely employed by Blue Cross VT for Modifiers 25 and 59 beginning on January 1, 2023 – you may have heard from providers in your community about this specific topic.

Prepayment Coding Validation Edit Review

Let's start with the last issue first – prepayment coding validation edit review. On January 13, 2023, Blue Cross VT implemented several claims edit changes, one of which was changing the edits for Modifiers 25 and 59 to pre-payment review instead of post-payment audits. While we believe that the application of the claims edit is important, the rollout of these changes – specifically the prepayment review did not go smoothly. Blue Cross VT underestimated the impact this change would have on some providers, and we were unprepared to handle the number of questions and issues that arose from the changes. For this I would like to apologize to our health care community, we are committed to doing better in the future.

H.766 addresses this issue specifically on page 6 (e)(1) and (2) where prepayment coding validation edit review will be prohibited beginning on January 1, 2025 except in certain more narrow circumstances.

Process for adopting claims edits

Current law requires health plans to submit their coding changes to DFR in advance of implementation and then give appropriate notice to providers before implementation, among other requirements. This bill would only allow claims edit changes quarterly going forward, and lays out a process for keeping current with CMS coding changes (page 5 at the bottom (d) going into page 6). While this is very restrictive, it's probably workable.

Limiting Claims Edits to only Medicare NCCI and MCE

The final topic: the changes made to the overall application of coding edits is where Blue Cross VT has the most concerns, on Page 4 (b)(1)

(A) restricts outpatient and professional claims edits to only NCCI edits used by Medicare
(B) restricts facility claims edits to only Medicare Code Editor used by Medicare
(C) excludes pharmacy claims edits
(D) allows DFR to approve nationally recognized standards, guidelines or conventions for any claim not covered by A, B, or C

These severe restrictions on a private health plan's ability to apply claims edits except those used by Medicare is extremely problematic because:

- Commercial health plans pay providers far more for the same services than Medicare and identifying inappropriate coding has a far greater cost impact

- Blue Cross VT covers a number of outpatient, professional and facility claims that Medicare does not.

Examples of providers paid by commercial health plans who do not contract with Medicare includes:

- Naturopaths
- Licensed Alcohol and Drug Counselors
- Psychologists
- Board Certified Behavioral Analysts
- Certified Midwives
- Acupuncturists
- Athletic Trainers
- Hearing Instrument Specialist or Hearing Aid Dispensers
- Licensed Genetic Counselors
- International Board-Certified Lactation Consultants (IBCLC)
- Licensed Professional Counselors
- Pharmacist Performing Medication Therapy Management Outside of a Retail Pharmacy Setting

That was a short list of some of the provider types that don't interact with Medicare. Health plans also pay for many thousands of services, procedures and equipment not covered by Medicare.

- Inappropriate coding costs commercial members directly in increased out of pocket costs – 40% of our members have high deductible health plans – and increases premiums for everyone – that isn't true of Medicare members.

- Limiting claims edits to only Medicare for Vermont Qualified Health Plans puts us far out of line with other payers in the state and nationwide. Blue Cross VT is a local carrier, but we cover claims submitted from providers across the country – not just VT-based providers – and we need to be competitive, current, and protect our members from inappropriate claims on a scale that is much larger than our state. This hinders our ability to do so.

- Also, I mentioned earlier that I participated in the claims edit standards workgroup. One of the suggestions that led to that work group was that commercial payers should only use NCCI edits as used by Medicare. With the former head of VAHHS Paul Harrington leading our work group, we went through every NCCI edit, and the provider representatives on the workgroup rejected them. They reached the same conclusion that we did: NCCI edits are not devised for commercial payments.

- Where is the improved access in limiting claims edits in the way proposed? If we can't edit the claims, we're either going to pay them as billed and pass on this wasteful spending to premiums or deny the claim because it's so out of line. Neither of those scenarios improves access to care.

Requested Changes to H.766 Section 2

Because of these issues we are asking you to either:

1. Allow nationally recognized standards, guidelines or conventions for all types of claims

or:

2. Add to pharmacy claims in (C) – any claim type not covered by Medicare; and

3. Do not restrict DFR in (D) from approving claims edits if they see fit for A, B, or C and please remove the underlined language in (D) "for any other claim not addressed by subdivision (A), (B), or (C) 12 of this subdivision (1)" and

4. Please consider "grandfathering" existing claims edits that we had in place prior to January 1, 2023. A number of the Claims Edits being eliminated or rolled back by this section Blue Cross VT has applied for many years. This is where we account for a good portion of the estimated costs in this bill.

Finally, we understand that provider sustainability and the elimination of administrative work for providers are important priorities for Vermont. We support those priorities and this body's pursuit of those goals. However, we implore this committee do that work in a way that doesn't pass on additional costs on to our clients and members. And I'll end where I started, please be sure that the significant increase in costs you are passing onto your constituents is a viable path.