Addressing Inaccurate Coding for Health Care Claims

Tennesseans are facing an affordability crisis. Health care costs are surging, and one of the major drivers of these increases is inaccurate coding.

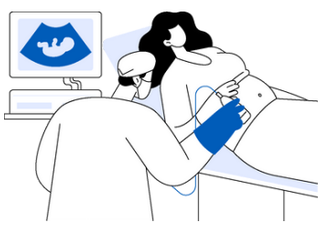
We value the work providers do, and we want them to be paid accurately, but we must balance this with our responsibility to control practices that lead to higher costs for the members we serve.

Our claims edits are one way we're ensuring provider coding is accurate and that our members are paying appropriately for their treatment and care.

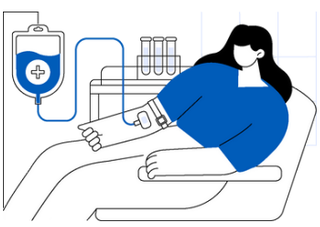
Inaccurate Coding and AI

Some large hospitals and provider groups now use AI tools to help read clinical notes and suggest diagnostic codes that could be submitted on a claim for payment. Used appropriately, this technology can improve efficiency and accuracy. But, it can also drive costs higher, without improving patient care.

Here's a real-life example of inaccurate coding we've seen at BlueCross and how it leads to rising health care costs:



Diagnoses of acute post-hemorrhagic anemia in maternity cases increased over a period of 3 years.



During this same time period, rates of transfusion (a treatment for this condition) remained flat. If there were a genuine increase in the condition, we'd expect treatment rates to rise as well.

Since claims were coded with the diagnosis, we paid $2.6 million more to providers even though more care wasn't delivered.

Inaccurate coding affects health care costs for everyone – additional costs of care create greater out-of-pocket expenses for our members and increased premiums for our employer groups.

What We're Doing

Because we recognize that inaccurate coding is a major driver of costs, we're taking steps to proactively address it.

- Our review process ensures that reimbursement for higher-level codes is supported by clinical evidence in the medical record.
- **Our reviews always include oversight from expert members of our medical and claims teams.** Any claims adjustments are made by a human clinician. **We do not use AI or other software to make claims adjustments.**
- Claims edits apply only to a small, targeted segment of our overall provider network – those who code at a disproportionately higher level than their peers.
- We regularly review providers whose claims are subject to edits and remove our changes if codes are supported by clinical evidence.
- Providers can easily identify adjusted claims on their remittance – we indicate which claims have been adjusted due to lack of clinical evidence.

This enhanced process not only allows us to catch more discrepancies before paying claims, but also:

Reduces overpayments

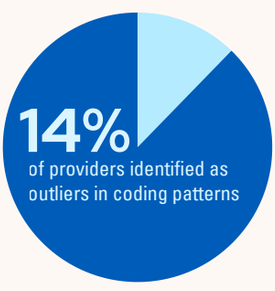
Ensures fair pricing

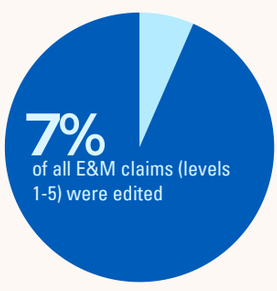
Improves efficiency

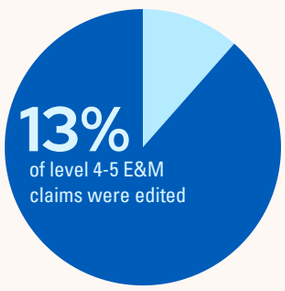
By implementing new tools, we can keep improving how claims are processed with greater accuracy, saving our members and customers money.

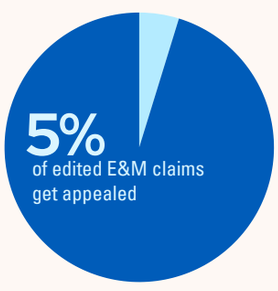
By the Numbers

The total number of providers identified and claims that get edited is small compared to the number of providers in our networks and claims processed each year – but these reviews still result in measurable savings for our members. *See the chart below for a breakdown of the numbers based on only evaluation and management (E&M) claims.*









Average Savings Per Claim Line

$24 ↘ Medicaid

$37 ↘ Commercial

$27 ↘ Medicare Advantage

Learn more about our efforts to support affordability at BCBSTWorksForYou.com