MASSACHUSETTS

EMERGENCY DEPARTMENT CLAIM (EDC) ANALYZER APPEALS GUIDELINES

For contracted acute care hospitals

OVERVIEW

Starting for dates of service on or after October 10, 2025, Blue Cross uses the Optum®" Emergency Department Claim (EDC) Analyzer tool to review facility outpatient emergency department claims on a pre-payment basis to help determine appropriate level of care coding for evaluation and management (E/M) services.

Please refer to this document when submitting an appeal for a claim that was adjusted by the EDC Analyzer tool. The purpose of this document is to ensure appropriate use of the appeal process by highlighting:

- Valid appeal scenarios
- Correctable billing issues (via replacement claim)
- Non-appealable outcomes aligned with editor logic

Please submit an appeal only when material resource utilization occurred but could not be represented through standard billing in the claim-level data. As you know, appropriate use of the appeal process improves efficiency, reduces administrative burden, and allows for greater focus on truly exceptional cases.

Related resources:

- To learn more about the tool, review Optum's EDC Analyzer guide.
- For billing guidelines, refer to our Emergency Room – Facility payment policy (log in and click on Office Resources>Policies & Guidelines>Payment Policies).
- To read our original News Alert announcement, log in and click on News, then look for the News Alert dated July 1, 2025.

WHEN TO APPEAL

Examples of when it is appropriate to appeal:

- Non-billable resource intensity (e.g., prolonged monitoring, observation, reassessment)
- Operational complexity not captured in coding (e.g., behavioral health management, safety monitoring)
- High staff resource utilization (e.g., combative patients, multi-staff interventions)
- Technology or infrastructure use not reflected in claim lines (e.g., specialized equipment)
- Documentation supports higher intensity than claim-level data indicates

Documentation expectations:

- Clear rationale and medical record to support use of additional resource consumption
- Evidence that intensity exceeded what is typically represented by billed services
- Highlight or circle where increased intensity exists within medical record

continued

WHEN TO SUBMIT A REPLACEMENT CLAIM

If the resource use can be accurately reflected through corrected billing, please submit a replacement claim instead of submitting an appeal.

Submit a replacement claim when the issue is due to incomplete, incorrect, or missing billing information. For example:

- Missing or incorrect revenue codes, CPT/HCPCS codes, or modifiers
- Missing diagnosis coding that represents the most specific and highest acuity of the episode or care
- Omitted billable services or procedures
- Billing system/interface errors resulting in incomplete claims

WHEN NOT TO APPEAL

Appeals are not intended to re-adjudicate claims using the same information.

Do not submit an appeal when the outcome reflects appropriate application of the EDC Analyzer tool based on submitted claim data. For example:

- Disagreement with the ED leveling methodology
- Reliance on internal facility scoring tools that differ from payer methodology
- General statements of “high complexity” without new supporting details
- Requests to override standardized editor logic without new information
- Appeals without additional documentation beyond the original claim

SCENARIO EXAMPLES

For this scenario:	This is the appropriate action:
Missing or incorrect billing data	Submit a replacement claim
Additional resource use not visible on claim	Submit an appeal with clear documentation
Disagreement with EDC Analzyer tool outcome	Do not appeal