



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

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 Analyzer tool outcome	Do not appeal