MASSACHUSETTS

EVALUATION AND MANAGEMENT OVERCODING PROGRAM

Questions & Answers for providers

Overview

Effective for dates of service on or after November 3, 2025, Blue Cross has expanded our pre-payment claims editing to review professional services for evaluation and management (E/M) overcoding. We will assess level 4 and 5 E/M codes to determine if the level of service billed is appropriate for the severity of the member's condition as reported on the claim. If we identify overcoding, we may adjust reimbursement to a lower-level E/M.

This program will apply to:

- Office visits for new and established patients and emergency department visits
- Commercial, Federal Employee Program (FEP), and Medicare Advantage members
- Professional services only, and is different from the Optum® Emergency Department Claim (EDC) Analyzer tool for facility claims

Ensuring that our members have access to safe, effective, and affordable care is our top priority. We review the care our members receive to ensure that treatments benefit the member and manage health care spending, which is increasing at its fastest rate in more than 20 years. We're constantly evaluating our review process, including our clinical, coding, and billing policies.

To help mitigate overcoding, Blue Cross is expanding its claims review process. We will review claims for certain providers that bill visits at the highest complexity levels to ensure the services billed match the severity of conditions reported. Reimbursements may be adjusted if overcoding is found.

This program will apply to providers who frequently code at higher levels for office visits for new and established patients and emergency department visits. This program will apply to our commercial, Medicare Advantage, and Federal Employee Program (FEP) members.

We have an appeals process in place for providers to request reconsideration if they feel a service was inaccurately adjusted. If you disagree with how a claim was processed with regards to the E/M overcoding program, you may submit an appeal with complete medical records. For more information on the appeals process, including our Request for Claim Review form, visit our Reviews & Appeals page.

Related communications (to view these, log in to Provider Central and click on News):

- August 4, 2025 News Alert: Evaluation and management overcoding program
- September 15, 2025 News Alert: Clarification on our evaluation and management overcoding program

Questions & Answers

Q: Why is Blue Cross implementing this E/M overcoding program?

A: The E/M overcoding program promotes more accurate coding by evaluating claims and ensuring that the level of E/M service reported by the provider reflects the services performed.

Q: How does this program work?

A: Our program compares a provider's billing patterns, specifically the frequency of high-level E/M codes (level 4 and 5), against clinical peers who have similar patient populations and medical decision making complexity. When these providers submit E/M services that exceed the maximum level of E/M service based on the diagnosis and other claim information, the E/M code is reduced to reflect the maximum level.

The edit is designed to pay the claim at the appropriate lower level when overcoding is identified, rather than denying the entire service. This ensures the provider is reimbursed for the service delivered while preventing overpayment.

Q: If a claim is impacted by the program, what will that look like?

A: If an edit is applied, the original E/M code will be denied, and a line will be added with the newly adjusted E/M code. The claims editing program would edit the original E/M as follows:

- Level 5 E/M code/reimbursement may be adjusted to level 4 or 3
- Level 4 E/M code/reimbursement may be adjusted to level 3

Within the guidelines of this program, we will never perform any of the below actions:

- Fully deny the E/M without adding a lower level
- Adjust the E/M to lower than level 3

Q: Will the claim edits apply to all level 4 and 5 E/M codes or only a subset of claims?

A: The program will only apply to a subset of outlier providers. The program reviews claims based on the individual provider identification number, not by the tax ID or group.

Q: How many providers are eligible for this program?

A: This program is designed for a specific, limited group of providers. At launch, we estimate that the program will include only 1% to 4% of the PCPs and specialists in our network; the vast majority of providers will not be impacted by this initial phase.

Q: Are there any scenarios where providers may be exempt from this program?

A: During our periodic review of data, we may add or remove providers from the program based on their billing patterns. Only outlier providers are included in the program.

Q: Why are you focusing on level 4 and 5 E/M codes when these are to be expected in the emergency room and with certain specialties?

A: Blue Cross' analysis of paid claims shows a significant rise in the frequency of level 4 and 5 E/M claims that exceed clinical justification. CMS' own studies have also concluded that E/M services are disproportionately likely to be paid in error. We target these highest-level claims to reduce this industry-wide trend of overcoding.

Q: What remittance code and messaging will I see if my E/M claim has been edited?

A: Remittance code and messaging will vary based on how you receive paid claim details.

Payspan Provider Detail Advisory (PDA):

Includes HIPAA claim adjustment segment (CAS) coding and Blue Cross' message narratives. These codes and messages will be displayed on the PDA if an E/M coding edit is made.

- The 'Submitted Procedure' E/M code and 'Corrected Procedure' E/M code are displayed on the corresponding claim line.
- The K769 message code is unique to the professional E/M overcoding review and will only be used for claims that have been edited through this program.
    - K769: SUBMITTED E/M CODE DENIED. LINE ADDED WITH REDUCED E/M CODE BASED ON DIAGNOSTIC INFORMATION. THE INFORMATION SUBMITTED DOES NOT SUPPORT THE LEVEL OF SERVICE. /K769/

Electronic Remittance Advice (ERA/835 - Delivered to provider/clearinghouse):

Includes customized indication of a downcoded claim. Providers should share the remittance advice with their clearing house if they do not see the downcoding indicator as described below.

- 2300 Loop under claim information, refer to the REF segment for the 9A qualifier with DOWNCODED verbiage.
    - Example: REF*9A*DOWNCODED~

Provider Voucher (mailed to providers who are either still paid by paper check or have enrolled for EFT but the 90-day paper suppression countdown hasn't expired yet):

Includes Blue Cross' message narratives, which will display on the voucher if an E/M downcoding edit is made.

- The Provider Voucher will display K769 and K825 message codes.
    - K769: SUBMITTED E/M CODE DENIED. LINE ADDED WITH REDUCED E/M CODE BASED ON DIAGNOSTIC INFORMATION. THE INFORMATION SUBMITTED DOES NOT SUPPORT THE LEVEL OF SERVICE. /K769/
    - K825: A NEW LINE WAS ADDED TO THE CLAIM AND INCLUDES PAYMENT FOR RELATED SERVICES PERFORMED ON THE SAME DATE. /K825/

Q: Is this a change to the Evaluation and Management payment policy or reimbursement guidelines?

A: No. Our E/M payment policy and coding guidelines have been in place for several years. Our payment policies, including those for E/M services, are firmly grounded in national coding guidelines and CMS documentation standards. They are both developed and continuously validated by our clinical team, including expert nurse coders and medical directors, to ensure clinical rigor and compliance with industry standards.

Q: Will these claim edits materially delay claim payment?

A: No, this program is not expected to materially delay claim payments to providers.

Q: How can you edit my claim without looking at medical records?

A: This pre-pay program is designed to minimize administrative burden. It applies advanced analytics and peer comparison data instead of medical record review to efficiently identify statistical outliers and their claims with the highest potential for inappropriate coding. This approach allows us to pay claims appropriately and efficiently, reserving medical record review only for the appeal process.

The diagnostic information reported on the claim should reflect the complexity of a member's condition. Members with more severe illnesses will tend to have higher level E/M codes billed. The program evaluates the current claim information and related member history to determine that E/M levels align with the services billed. If the coding is appropriate, the program won't recommend editing.

Q: The level of E/M I billed on my claim is based on time and not medical decision making. Why did you edit my claim without considering the time aspect?

A: For office visits, Blue Cross recognizes the 2021 AMA E/M guidelines where the level of service for a visit is based on either medical decision making or time. We maintain that time should correlate closely with the expected level of medical decision making in most clinical situations. We would not expect providers to document a lot of time for conditions that do not require a high level of medical decision making. We understand that there may be exceptions to this principle, but these would be evaluated on appeal with medical records.

Q: Is it considered ethical to use an algorithm to make coding edits without manual human review?

A: The program is not based on artificial intelligence or any arbitrary rationale. Instead, it upholds clinical accuracy and national coding guidelines to fulfill Blue Cross' fiduciary responsibility. The use of analytics allows us to target only statistically significant outliers: providers whose billing patterns deviate substantially from their specialty peers. We operate with the presumption that the vast majority of providers act in good faith. We focus on precisely correcting the small percentage of outlier coding to ensure appropriate payment accuracy.

Q: Have you considered that downcoding my claims will cause an undue financial burden on my practice?

A: We recognize the financial implications that this program could have on providers. However, our primary duty and fiduciary responsibility is to ensure the responsible stewardship of health plan dollars. Our targeted approach focuses only on the most significant outliers.

Q: How are appeals handled?

A: Appeals for claims that were impacted by this program will follow our standard process. Appeals are not reviewed by the same analyst that reviewed the original claim. Subsequent appeals are also reviewed by different analysts.

Q: If I appeal and successfully overturn your determinations for this program, can I be removed from it?

A: We automatically remove providers from the program when their high-level E/M coding frequency returns to what is considered normal (based on comparisons to their peers) for a sustained period of time (typically six to twelve months). This program is designed to be corrective and not punitive, focusing on encouraging the provider's billing patterns to align with those of their specialty peer group.

MPC_072125-2W-3-QA (3/26)