TMA
Tennessee Medical Association

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July 22 , 2026

Hon. Carter Lawrence
Commissioner, Tennessee Department of
Commerce & Insurance
500 James Robertson Pkwy
Nashville, TN 37243-0565

Dear Commissioner Lawrence,

Since March 3, 2025, BlueCross BlueShield of Tennessee (BCBS-TN) has engaged in sytematically "downcoding" many Evaluation and Management codes and other codes attached to health insurance claims submitted on behalf of patients by Tennessee physicians. The process of downcoding claims involves the carrier's practice of modifying service codes, especially E/M codes, on claims submitted by physicians to lower-level and lower paying codes.

On March 3, 2025, BCBS-TN initiated its "E/M Overcode Program" that "[i]dentifies outlier providers who consistently overcode E/M services" and that utilizes algorithms to evaluate high-level office and outpatient E/M services based only on claims data. Without adequate explanation to the physicians submitting the claims, BCBS-TN automatically adjusts the claim and pays it at a lower level if the algorithm flags the claim.

One problem with BCBS-TN's scheme is that its algorithms read the claim's diagnosis codes vis-à-vis the submitted code instead of reviewing the medical record from the visit. A proper evaluation of the appropratelness of a submitted E/M Code requires a determination of the patient's history and examination, complexity of medical decision-making, and the time spent by the provider with the patient. Such determination can only be made from a review of the patient medical records from the visit. Yet, BCBS-TN typically does not review the medical records prior to automatically downcoding claims. The algorithms BCBS-TN uses to downcode claims do not review or take into consideration the medical records from the visit.

Another problem with BCBS-TN's downcoding practices is that it reduces the codes on many claims that are properly submitted. It treats the physician as guilty unless/until the physician proves himself/herseof innocent pursuant to an appeals process that takes months to complete. If the physician identifies that the claim has been downcoded and disagrees with the downcoding, the physician must submit further documentation through an appeal process establishd by BCBS-TN. The appeals process takes several months for a decision to be made by BCBS-TN. BCBS-TN has aknowledged it has experienced a backlog of appeals pending its review. TMA is aware of physicians who have had dozens or even hundreds of

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pending appeals at a time. Also, practice-level reports indicate that the cost to a medical practice to process one of these appeals is approximately the same cost as the difference between a level of payment. For example, the cost to a medical practice of appealing a level 4 claim automatically paid as a level 3 claim is about the same difference as the difference in payments between a level 4 and a level 3 visit. Therefore, BCBS-TN's process discourages legitimate challenges and allows BCBS-TN to pocket millions of dollars it otherwise would not be entitled.

The physicians who appeal on principle or appeal in an effort to try to be removed from the outlier list, report that they win appeals a vast majority of the time. BCBS-TN has even aknowledged to TMA's leadership that physicians win approximately 60% of the time. Some physicians have reported to TMA that they win 90% or more appeals.

Yet another problem with BCBS-TN's downcoding process is that it contravenes the Tennessee Prompt Pay Act. Tenn. Code Ann. § 56-7-109(b)(1)(A) states in pertinenet part regarding claims submitted on paper:

b)

> (A) Not later than thirty (30) calendar days after the date that a health insurance entity actually receives a claim submitted on paper from a provider, a health insurance entity shall:
>
> (i) If the claim is clean, pay the total covered amount of the claim;
> (ii) Pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid; or
> (iii) Notify the provider in writing of all reasons why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean.

The statute in subdivision (B) states:

> (B) Not later than twenty-one (21) calendar days after receiving a claim by electronic submission, a health insurance entity shall:
>
> (i) If the claim is clean, pay the total covered amount of the claim;
> (ii) Pay the portion of the claim that is clean and not in dispute and notify the provider why the remaining portion of the claim will not be paid; or
> (iii) Notify the provider of the reason why the claim is not clean and will not be paid and what substantiating documentation or information is required to adjudicate the claim.

The applicable definition of "clean claim" is included in Tenn. Code Ann. § 56-7-109(a)(1):

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(A) "Clean claim" means a claim received by a health insurance entity for adjudication that requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health insurer. A claim is clean if it has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section;
(B) "Clean claim" does not include a duplicate claim;
(C) "Clean claim" does not include any claim submitted more than ninety (90) days after the date of service; and
(D) "Clean claim" includes resubmitted paper claims with previously identified deficiencies corrected;

In the course of downcoding claims pursuant to its E/M Overcode Program, BCBS-TN fails to comply with the requirements of Tenn. Code Ann. § 56-7-109(b)(1)(A)(ii) and (b)(1)(B)(ii) because it pays only portions of claims, the downcoded rates, but does not adequately notify the provider in writing why the remaining portion of the claim will not be paid.

Based on the definition of "clean claim" in the statute, the unpaid (downcoded) portion fo the claim is either not clean or in dispute. Either way, BCBS-TN is required to "notify the provider in writing why the remaining portion of the claim will not be paid" or "[n]otify the provider in writing of all reasons why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean."

The reasons BCBS-TN gives for not paying the remaining portion of the claim (the dowcoded) portion are provided via its own codes on the remittance advices and are completely illigitimate and non-compliant because such codes make it impossible for anyone to understand why a claim is not clean or why the remaining portion of the claim will not be paid. For example, on some downcoded remittance advices BCBS-TN uses a "CO-45" code. CO stands for Contractual Obligations. The 45 means that the "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contrctual reductions) that have resulted from prior payer (s) adjudication. (Use only with Group Codes PR or CO depending upon liability." When the provider checks their submitted charge with their fee schedule, the charge matches their fee schedule. BCBS-TN points to no contractual or legislated fee arrangement to justify their conclusion that the physician submitted a charge that is higher than their fee schedule. This code does not seem to have anything to do with downcoding.

Another code used by BCBS-TN on its remittance advices is N56 – "Procedure code billed is not correct/valid for the services billed or the date of service billed." BCBS-TN cannot determine if an E/M Code is incorrect or invalid without reviewing the medical records of the visit being billed. BCBS-TN apparenlty asserts it has an algorithm that can take the place of such a review. However, such assertion

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flies in the face of established criteria for determining the validity of an E/M Code, which requires a medical record review. Only if the provider appeals does such provider receive a review of the medical records. By BCBS-TN's own admission, more than half, nearly 60% of appealed claims are reversed in favor of the provider's originally billed charge. A procedure not billed correctly/validly for the services billed is vague and provides no information to the physician as to why the claim was not paid as submitted.

Furthermore, Tenn. Code Ann. § 56-7-109(b)(4) requires any health insurance entity that does not comply with subdivision (b)(1) to pay one percent (1%) interest per month, accruing from the day after the payment was due, on that amount of the claim that remains unpaid. Despite the many weeks or months it takes BCBS-TN to process downcoding appeals, it has not paid interest on the claims on which the provider prevails during appeals. BCBS-TN owes interest calculated on the difference between the billed code and the initially downcoded claim.

At least one other state insurance commission has taken action against a health insurance carrier for this type of automatic downcoding. The Maryland Insurance Administration issued a significant fine against Cigna in March 2026 and ordered Cigna to "... cease the automatic reduction of the code level of billed evaluation and management codes...". An $80,000 civil penalty was assessed.

The Tennessee Medical Association requests that the Department undergo a thorough investigation of BCBS-TN's systematic downcoding of health care claims submitted by Tennessee physicians. We strongly urge the Department to issue an order to BCBS-TN to cease its E/M Overcode Program and consider issuing civil penalties against it. Thank you for your attention to this matter. Please reach out to me, Yarnell.Beatty@tnmed.org or 615-4601644 if I can provide any additional information.

Sincerely,

Yarnell Beatty
Senior Vice President and General Counsel
Tennessee Medical Association