While this letter is addressed to BCBS, it quickly became more than just an appeal letter to cover the expenses of an Emergency Department encounter. The fact is that quality patient care is a shared responsibility of all parties that work with health information and the patient is not the one that should have to endure the hardship of failed processes. A patient, in this instance my 20 year old son, did not go to school to learn patient rights, privacy, compliance, revenue cycle/reimbursement methodology, or diagnostics and clinical care. You don't know what you don't know, and it is my personal belief that this is taking advantage of the situation by not evaluating processes that ensure the well-being of the patient, both clinically and financially.

Re: [redacted]
MRN: [redacted]
BCBS of Alabama policy number: [redacted]
Claim Numbers: [redacted] *and* [redacted]
Claim amount: ***$2,352.00*** *and* ***$12,610.25***

BCBS of Alabama
Attention: Customer Service Appeals
P.O. Box 12185
Birmingham, AL. 35202-2185

Re: [redacted]
BCBS of Alabama policy number: [redacted]
Claim Numbers: [redacted] *and* [redacted]
Claim amount: ***$2,352.00*** *and* ***$12,610.25***

The goal of this first section is to set the reason for the ED visit, and give some background that cannot be submitted on a claim form. This gives context surrounding the attempt to seek care according to the plan plan policy that cannot be captured in a diagnosis code.

[redacted] presented to the Emergency Department on 3/25/2020 after having symptoms for several days that were very much in line with spinal meningitis. Prior to visiting the ED at [redacted], he showed up at an urgent care who would not see him and the ED was the next closest place open. Houston was closed as the numbers for COVID were rising and executive orders were issued across the country. He was still working so he tried to seek care when the symptoms were not going away and new symptoms kept developing. At this time, he could have had COVID-19 based on what we know about the disease and how it impacts generations differently. However, a COVID-19 test was not done because everyone fixated on 3 symptoms that have not held true for every positive case. A statewide order, which is attached, was issued 3/31/2020 and it states the novel COVID-19 virus poses and imminent threat of disaster for all counties in the state of Texas represents a public health disaster. Prior to this order, you will find another order that states the initial executive order to close the state was issued on March 13, 2020. A copy of his medical records are attached to this appeal that does not include ALL OF HIS SYMPTOMS that led to him pursuing evaluation by a healthcare professional IMMEDIATELY.

The covid comment is hindsight and very subjective, which is irrelevant commentary for the background. This was a mother's concern because no one knew enough to identify best practice protocols at that time.

<u>Here are the facts of my son's symptoms and why he sought care:</u>

This is a list of symptoms my son had been experiencing. I kept a written list of what he told me via text or phone call. I used this to establish why he sought care.

- Eyes hurting – when he looked anywhere other than straight there was pain
- Pupils weren't pointing in the same direction at one point
- Pressure felt in eye area when looking sideways
- Throat tightening up – it was described as resisting when trying to swallow
- Headaches were frequent with activity
- Lightheadedness was happening at times
- [redacted] does live in an apartment with other guys when he travels and is in close contact with groups of people which is another warning sign of bacterial meningitis.
- It is inconceivable to think that a 20-year-old, or any patient for that matter, will remember to provide all of these symptoms when he is already not feeling well.

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This section is irrelevant to writing an appeal. However, highlighting the sections in the medical record that support the reason care is sought is always a good idea.

Documentation in the medical record:

- Inconsistency between triage and Physician Clinical Report documentation

Documentation	Triage	Physician Clinical report
Chief Complaint	Stiff neck and cough (non-productive)	Headache and low-grade fever. Described as a global headache and has had neck pain (3/10)
Fever	No fever – but ironically temp is documented as 99.1	Low-grade fever Temp documented as 99.1
Pain severity	3/10	At its maximum 5/10. When seen in the ED severity described as 5/10
review of symptoms	Has had a nonproductive cough	No cough
Physical Exam	See pain severity WHICH DOES NOT MATCH CHIEF COMPLAINT in the physician's report	Pain level now 3/10 which matches triage but DOES NOT MATCH CHIEF COMPLAINT in the physician's report.
Appearance	Appears in no acute distress	Patient in moderate distress
Neck	n/a	Mild meningeal signs present as evidenced by neck stiffness
Course of care	n/a	Do have concern for meningitis and will need workup in light of his symptoms.

Here I re-stated the background of why my son ended up in the emergency department, why the medical policy should not be upheld under the circumstances, and a lot of frustration because of the situation that should have been resolved without placing burden and unnecessary stress on the patient.

Facts restated:

- [redacted] was working out of town when symptoms first occurred, so a primary care physician was not an option.
- He tried to go to a different source of care first but was ***REJECTED***. The Urgent Care facility turned him away saying they are unable to assess whether he had meningitis or not.
- He only went to the ED because it was the only other source of care available.
- Attached you will find the executive order showing a statewide executive order to close the state was ***IN EFFECT*** which is why ***HE WAS LIMITED*** in the care he could seek and why he ended up at an ED – ***NOT BY CHOICE***.
- The coverage exclusion of what is defined as an EMERGENCY should not be upheld due the state of the nation which has ***IMPACTED ACCESS TO CARE*** for ***EVERYONE,*** and *it was*

necessary to seek care immediately at that point in time! Reminder of bullet #2 where he was rejected at the Urgent Care.

- A follow-up call for an appointment to the provider listed on the discharge summary was attempted but **NO ONE ANSWERED AS THE WORLD WAS IN A STATE OF CLOSURE. FOR THE LIFE OF ME, I CANNOT UNDERSTAND WHY YOU ARE WASTING MY TIME AND CONTINUE TO DENY CARE BASED ON COVERAGE THAT DOES NOT ALIGN WITH A PANDEMIC and the CDC's description of Bacterial Meningitis where death can occur in as little as a few hours?????**
- The severity and potential harm from his symptoms and the **NON-EXISTENT** access to other methods of care at the time of his symptoms warrants an over-ride on the non-covered services deemed incorrectly as a 'non-emergent' visit to the ED based on the circumstances provided and ***payment for services should be processed as covered immediately***.
- Due to your negligence in recognizing a global pandemic and paying the claim like a caring company should, my 20-year-old who is insured by YOUR COMPANY, BCBS of AL, who makes $10 an hour is being harassed by the hospital trying to collect payment for a $12,600 and $2300 bill that he sought care for because the symptoms could have very well been life-threatening.
- **IT IS NOT OUR FAULT THE WORLD SHUT DOWN**. As an INSURED person paying a MONTHLY premium, ***this claim should be processed IMMEDIATELY*** despite whatever coverage code exists on the group contract preventing payment.
- **THIS IS NEGLIGENT** on your part to deny coverage of care when access to care was limited in the state of a pandemic and based on the fact his symptoms could have been serious – even deadly – and **ALL LITERATURE** suggests that care should be sought **IMMEDIATELY** to rule any meningitis out. https://www.cdc.gov/meningitis/bacterial.html

The hospital would only take 40% off of the bill, which frustrated me even more. This is where I pulled together all of the information: the journey to seek care, the reason he sought care, the review of our health insurance policy, the CDC guidance of his symptoms, and his medical records to begin this process.

It is unacceptable for a company with a $43 million profit to not have appropriate procedures in place to respond to a global pandemic. It isn't that you didn't process the claim immediately, it is that BCBS of AL has not done anything ***EVEN AFTER A PHONE CALL*** to help the situation. You have pretty much placed your profit over a 20-year old's life when the indications pointed to being evaluated immediately based on standards of care and literature that support his need to seek care right away.

This is not a BCBS problem. This is my frustration with the whole healthcare system. Account management in healthcare is handled one transaction (claim/ encounter) at a time and one organization at a time, which only leaves a partial picture of the patient's overall health. There are many elements that cannot be captured, shared, or used to make decisions and this leaves parts of healthcare very blinded. This unintentional blind spot negatively impacts the patient.

Outside of claims processing that penalizes patients who need care based on standards set forth by what could happen, and not having access to care, we have a larger issue highlighted here. Due to the nature of this situation, and after reviewing everything above, I am sending a copy of this to as many as I can in hopes that we can highlight why healthcare is so broken and patient outcomes are so poor. This has to stop, and we need a much swifter response to correct the years of poor decisions and processes that have been allowed to continue which just cripple our healthcare system. We no longer operate in a paper world where information

needs to be organized the same way. Clinicians should not be expected to read long narratives or collect information in duplicates or triplicate because their time is precious and we need them to do what they were trained to do, provide care for us. The repetitive nature of collecting the same thing multiple times is inefficient. However, we have more than inefficiency here, we have a disconnect in the information captured within a medical record – a very small record mind you. Each category should have consistent data capture – if it is necessary to repeat the same information multiple times, then it should accurately reflect the patient journey so when it is used to assess or report out for others to use, it is ACCURATE. If this example alone does not highlight how poor EHR design leads to bad data collection which then leads to poor patient outcomes which then leads to bad medical coding for reimbursement which then becomes information used in another organization to make operational decisions which then leads to more regulation that tries to put a band aid on the root cause, then we are blind for not seeing it. Does anyone think about the data lifecycle when thinking about health information or are we all so caught up in 100-year-old paper processes that we just carry over into this century? We cannot continue to be stuck in our ways. Most patients are not looking at this from an analytical perspective and it shouldn't be their responsibility to ensure the appropriate information is captured and is correct. In this case, you are expecting a 20-year-old to understand everything that I have placed in this letter that highlights the dysfunction within our healthcare system. This information is not just for reimbursement or organizational use. This information leads to new approval of drugs, shifts in standards of care, new regulations….and the list goes on. This information could and did impact my son. It could impact one of your children, parents, grandparents, aunts, or uncles. We need to stop treating this like it is the clinical teams flaws and the patient's responsibility to correct poor design and process. It is the responsibility of every person on this letter to step back and look at the healthcare system outside of the chains we have bound it to when we locked in the archaic mindset of how health information should be created and maintained in a constantly changing environment.

As a person in healthcare, a mom, wife, and patient, I see the repetitiveness and margin of error whenever I have to look at situations like this. This is not specifically an EHR problem, it is not an organizational problem, and it is not an insurance problem. This is an overall healthcare issue that creates a lot of complication from all parties working independently of each other instead of in unison for the benefit of the patient.

I hope this letter achieves several things:

This is where is set the expectation of the outcomes. #1 for BCBS and #2 - #5 for everyone else.

1. Payment of both claims that were denied based on limitations that should not be set during a pandemic.
2. A better and more thoughtful method to collect documentation
3. A better process to ensure that it is consistent and accurate
4. A new thought process and thought leadership about what needs to change in healthcare and a collaborative approach to truly connect people, systems, and ideas
5. A shared responsibility to establish health information best practices based on the current needs and landscape that includes and considers the impact throughout the entire healthcare ecosystem.

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Sincerely,

Jeannine Pugh Cain

Jeannine Pugh Cain, MSHI, RHIA, CPHI

cc:

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[redacted]