# Health Insurance Claims Downcoding

## Rebecca Wartman OD March 2025 Extra

Many providers have reported that several different insurance companies have engaged in the automatic downcoding of claims. Auto-downcoding has been reported for claims sent to Aetna, Humana and Anthem Blue Cross-Blue Shield but could be more widespread. Each practice should review medical and vision plan claims to ensure that their claims are being paid the appropriate fee schedule amounts for each submission.

Claims auto-downcoding can occur in one of two ways. Some payors apply software algorithms to auto-downcode claims made for higher level evaluation and management codes or general ophthalmological examination codes. The claims are paid at a lower level because the software "decided" the submitted code was incorrect. Since the software is often proprietary, companies do not typically disclose the methods used to determine the which codes will be downgraded to a lower-level code. A second method that is sometimes applied is simply paying a lower fee than agreed upon fee when a higher-level code is submitted without actually telling the provider that the claim was altered. Provider can easily miss detecting this type of auto-downcoding. No matter what techniques insurance companies employ to downgrade claims, the impact is the same: a loss of revenue to the practice and undervaluation of the services provided to the patients. The cost of downcoding to providers extends into the costs, time, and energy required to engage with the insurers to appeal these decisions and receive the appropriate, often contracted, fees for services already supplied to patients.

That being said, providers must ensure the documentation for each service is appropriate, complete, and supports the codes submitted for each service. With detailed documentation in place, providers must understand and appropriately apply the coding guidance for evaluation and management (E&M) codes, general ophthalmological codes or procedures performed. Good documentation in the form of completed medical records is the first step to ensure appropriate reimbursement. Providers should use all the applicable diagnoses codes for each condition evaluated during a visit for each claim. Finally, providers must be well-educated on how to appropriately apply any examination or procedure code used for any claims to ensure that the documentation supports the code choice(s) made. Auto-downcoding programs do not rely on the review of medical records leaving the insurance companies to only review the CPT® and ICD-10-CM codes used on a claim.

Each provider should set aside the time required to review remittance statements (explain of benefits -EOBs) from insurance companies to ensure payments were accurate and consistent with the claims submitted and with the provider contract. If a discrepancy is noted, the provider should challenge each and every impacted claim. For many insurances, the successful appeal of inappropriately paid claims is the only way for a provider to be "removed" from their "auto-downcoding program". Several different EOB remark codes might be employed to indicate and auto-downcoded claim including:

CO150: Payer deems the information submitted does not support this level of service
M85: Subjected to review of physician evaluation and management services
N610 Alert: Payment based on appropriate level of care
CARC 186: Level of care change adjustment

The American Optometric Association strongly disagrees with the auto-downcoding employed by insurance companies. The AOA advocates that no insurance company should change a claim without first requesting and reviewing the actual clinical records. The AOA is actively engaged, on behalf of providers, with some of the insurance companies using these tactics and has been successful in getting some providers removed from auto-downcoding. However, the only way to be successful in getting removed is to request reconsideration of each impacted claim and to appeal claims if the reconsideration is denied.

Submitting appropriate supporting documentation is vital for a successful reconsideration or appeal. The medical record documentation should align with proper coding guidelines and should justify the level of service billed. The record should reflect that the necessary criteria for the E/M service level billed have been established. Per the AOA, "if you are included in a downcoding program based on your claims reporting history, please notify the AOA at

stopplanabuses@aoa.org ." The AOA also request that reconsiderations and appeals outcomes be reported to the same email address. Tools, along with a template for the 99xxx code reconsiderations and appeals and examples of strong documentation can be found here. Even though asking for a reconsideration and appeal is time-consuming, these actions are vital in the fight to get auto-downcoding stopped for good.

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