Monitor for Auto-Downcoding of Your Claims

Rebecca Wartman OD May 2025

The coding of patient encounters can certainly be a challenge. As everyone knows, the Evaluation & Management (E&M) coding rules were revised in 2021. One of the goals for revising the E&M codes was to reduce the "unnecessary" documentation that was required for E&M codes. Another goal was to reduce the need for claims auditing with more specific coding definitions and guidelines. All providers need to understand the guidelines for applying any codes that are chosen to describe any particular patient encounter. Medical record documentation, as stated many times in the past, must accurately reflect all of the examination and procedure codes chosen by the provider. Furthermore, providers should be cautious in their reliance on any electronic medical record (EMR) suggestions when choosing the visit coding as the EMR can be incorrect.

Over the last five plus years, insurance companies have begun to use proprietary algorithms to detect what they describe as a mismatch between the diagnosis and the examination/procedure codes used for a particular claim. The payers involved in this auto-downcoding do not actually request and review medical records. Providers across all of medicine are impacted by the downcoding practice. Auto-downcoding can take two different forms:

1. Changing the code that was actually filed to a lower-level service and paying based on the lower service level
2. Simply changing the amount that is paid for a particular examination level to a lower amount

Payers have stated that this approach is designed to "reduce the administrative burden of requesting, submitting and reviewing" the actual medical record for a particular claim.

Automatic downcoding typically occurs for the higher-level E&M codes of 99204, 99214, 99205 and 99215. However, the General Ophthalmological Codes can also be downcoded. Each insurance company has their own guidelines for when a claim is downcoded. The trend seems to be the insurance company's perception of a mismatch between the CPT® code choice and the diagnoses listed on the claim. Some providers are placed in auto-downcoding "programs" because they statistically used more of the higher-level E&M codes than some of their peers. A practice with complex patient populations might use higher level E&M codes with greater frequency. The use of higher-level E&M codes does not mean that the provider is over-coding their encounters.

Some practices may not be aware that their claims are being downcoded by the payer. The recommended approach to detect any downcoding would be to implement a policy of regularly reviewing claims payment data against the claims submitted to ensure that claims were paid appropriately. One might wonder if the insurance companies hope that providers do not notice they are paying less than is appropriate for a specific claim. If an instance of downcoding is detected or a provider is informed that their claims will be subjected to downcoding, the provider should review the medical record to ensure the documentation supports the original code submission. If the claim was indeed appropriately coded and filed, the provider should request a reconsideration or appeal the claim.

As a part of this appeals process, the actual medical record should be submitted along with any other supporting information. Please remember that no medical record should ever be changed after the fact. If addendums are necessary, these can be added but the provider needs to ensure that each addendum is signed and dated. While appealing each of these claims can be time consuming and expensive for the practice, this process is the only way to stop the auto-downcoding of your claims and to ensure the practice is appropriately compensated for the work that has been performed. One payer who has frequently uses auto-downcoding has stated that a provider in their program needs to appeal at least 75% of the involved claims and have at least a 75% success rate for their appeals in order to get out of the downcoding program. Otherwise, the insurance company assumes the downcoding was appropriate.

The AOA has produced several tools that a provider might use when appealing these claims. These tools include an appeal letter template and examples of adequate supporting documentation. As well *all* downcoding issues should be promptly reported to the AOA email: stopplanabuses@aoa.org. This email address is monitored daily and any concerns are addressed promptly. The AOA has been in regular conversations with the insurers involved in auto-downcoding and is available to help in overturning any denied appeals. Again, your medical record documentation must support the original E&M code that is filed in order for an appeal to be successful. Happy Coding….