Payer evaluation and management (E/M) downcoding programs

WHAT YOU NEED TO KNOW

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BACKGROUND

Effective January 1, 2021, substantive changes were made to the Evaluation and Management (E/M) services Current Procedural Terminology CPT® code set and reporting guidelines to reduce documentation burden on physicians and simplify coding. Documentation for E/M office visits is now based on medical decision making (MDM) **or** total time spent on the date of the encounter, and history and physical exam are no longer key components in selecting the appropriate E/M level. While these changes allow physicians to spend less time on documentation and more time with patients, some health plans are disputing E/M levels for submitted claims. Much to the frustration of physicians, payers are increasingly implementing E/M downcoding programs that inappropriately reduce payment for claims billed. This resource intends to support physician practices in navigating such payer E/M downcoding programs.

I. WHAT IS PAYER E/M DOWNCODING?

Downcoding occurs when a payer changes a claim to a lower-cost service than what was submitted by the physician, leading the physician to receive payment for a lower level of care than was provided. Most frequently, a claim is downcoded because the payer disputes the use of a high-level E/M code or contends that the diagnosis on the submitted claim does not warrant a high-level service code. An increasing number of payers are downcoding claims automatically using software algorithms, without first requesting and reviewing clinical records. Inappropriate downcoding by payers can significantly reduce revenue for physician practices, especially when it becomes routine or when a physician becomes subject to global prepayment review.

Examples of payer downcoding

The examples below provide an illustration of how and where downcoding might occur in practice.

Example 1: Emergent primary care physician (PCP) office visit with high level of MDM

Scenario: A 77-year-old male established patient with severe chronic obstructive pulmonary disease (COPD) who had been using a short-acting bronchodilator inhaler to control his symptoms in addition to his controller inhalers came to see his PCP emergently because his coughing, wheezing, and shortness of breath had recently worsened. The physician accessed and reviewed his medical record, including the patient's comorbidities of coronary artery disease and recent weight loss, performed an appropriate physical examination and pulse oximetry, ordered a chest X-ray for comparison and determined that an escalation of care and adjustment of medications was necessary. A complete blood count (CBC) with differential and basic metabolic panel (BMP) were also ordered. While there was some reduction in oxygenation, the patient did not require the initiation of oxygen therapy, and the radiograph as reviewed (but not officially read by the treating clinician) did not show pneumonia. The treatment plan included the addition of an oral steroid medication prescribed along with a bronchodilator inhaler to account for the exacerbation in the patient's chronic conditions. The physician discussed hospitalization with the patient, and they determined that given his support at home, he could be managed as an outpatient if he responded to the treatment.

Coding and downcoding: A total of 28 minutes was spent by the physician on the date of the encounter, and the physician reports CPT code 99215 based on a high level of MDM. That claim is automatically changed by the payer to a 99213 code (low complexity MDM). The physician is paid at the lower rate. Even though payment was adjusted, the payer does not change the billed code.

Example 2: Office visit with moderate level of MDM, diabetes

Scenario: A 64-year-old patient presents to the office complaining of pain and what she describes as a tingling/burning sensation in her extremities that has been occurring for the past several weeks. She is well known to the physician and was otherwise stable, being managed for diabetes mellitus type 2. The physician performs a relevant physical examination and orders thyroid stimulating hormone (TSH), vitamin B12, BMP and A1c tests as diabetic peripheral neuropathy leads the differential diagnosis. It is determined that the patient should be evaluated for peripheral neuropathy by a neurologist, and the physician refers the patient while continuing to manage her ongoing chronic condition.

Coding and downcoding: The physician selects CPT code 99214 to report the service based on MDM, and includes the diagnosis of type 2 diabetes with diabetic neuropathy, unspecified. The payer automatically reduces the E/M code to 99213 and pays at that rate, solely because the diagnosis is "diabetes." The billed code is changed, and remittance advice indicates a "level of care change adjustment."

II. E/M DOWNCODING POLICIES

To anticipate whether you may be subject to a downcoding program, it is helpful to understand the language used to communicate these payment adjustments. Many payers include downcoding provisions in their physician communications, contracts, or payment policies. These provisions may indicate that a payer uses software to downcode claims without a review of the medical record, that a payer reviews certain types of claims, or other practices; such provisions may mention "claim edits" or "reviews" of claims. Look to communications from payers with which you do business to see whether and how a payer may be downcoding claims. Below is example language that practices may encounter.

Example 1: Software algorithm

In an effort to reduce the administrative burden of requesting and submitting medical records for review, [Payer] will begin using [Proprietary Tool], which determines appropriate E/M professional coding levels based on data such as a patient's age and conditions for the Medical Decision-Making key component. [Payer] will presume the provider meets the requirements of the E/M code level they have submitted related to the History and Exam key components for the initial adjudication of the claim.

Example 2: E/M leveling—payment adjustment with no code adjustment

[Payer is] expanding our claim edits for E/M services [. . .]. This expansion enhances our prepayment claims editing process for coding policy rules related to correct coding of E/M levels of care for our members. [. . .] These edits evaluate the correct coding for level 4 and 5 E/M codes using the AMA E/M criteria. We will review claims billed with the following places of service: office, inpatient hospital, on campus—outpatient hospital, emergency room—hospital, off campus—outpatient hospital, and urgent care facility. Based on the outcome of the review, we may adjust your payment if the claim detail doesn't support the billed level of service. We will not change the procedure code you bill.

III. RECOGNIZING WHEN CLAIMS ARE BEING DOWNCODED

It is not always obvious when a claim has been downcoded, as payers are increasingly doing so unilaterally and without notice. As demonstrated in one example above, certain payers even pay at the adjusted lower rate without changing the billed code, making it extremely difficult to identify in coding audits. Physician practices must keep a vigilant eye on payment details to identify downcoded claims.

In order to discover downcoded claims, physician practices may need to adjust practice workflows to ensure remittance advice is reviewed regularly. Practices should work with their electronic health record (EHR) or practice management system (PMS) vendors to identify ways to simplify this step. For example, many EHR/PMS systems allow practices to run reports based on denial codes. Your vendor will likely be able to suggest efficient ways to alert practice staff of any downcoding.

A careful review of remittance advice will typically reveal downcoded claims, but some payers may downcode without providing notification of the adjustment. **In addition to scrutinizing payer adjustment codes in remittance advice, staff may need to review payment details, comparing the payment for each billed CPT code to the anticipated amount.**

Example Remark Codes

Review of payer remittance advice codes can help identify downcoded claims. The following language may indicate that a claim has been downcoded:

- 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*

Certain claims are more likely to be subject to downcoding than others. Pay special attention to claims indicating a high level of service (e.g., CPT 99204, 99205, 99214, and 99215) and complex claims, including those using modifier 25.

Tracking claim reductions and denials will reveal patterns, bringing to light coding errors and instances of downcoding. Identifying whether claims are downcoded only sporadically, or whether a certain payer downcodes your claims consistently, may help reveal whether you are subject to a payer's prepayment review program.

IV. GETTING PAID FOR DOWNCODED CLAIMS AFTER THE FACT

Given that many payers have instituted the practice of downcoding claims automatically, preventative measures may only go so far. Appeal is typically the only recourse once a payer has downcoded a claim or paid a lower-than-appropriate rate. The AMA advocates that any physician subjected to a downcoding program have the opportunity to provide supporting documentation *before* payment is reduced to avoid the additional administrative burdens associated with appeals.

Should appeal be necessary, the process will depend on payer policies. You may be required to submit a specific form, or to write a letter detailing the reason for the appeal. See the sample letter at the end of this document, which is also available as an editable template on the AMA website.

Generally, your appeal will include:

- Patient identifying information
- The relevant claim number and remittance advice
- Specification of the line item you are appealing
- The expected amount and the amount received and the billed and adjusted code
- Any contract provisions that may be violated
- Detailed explanation of the reason for appeal
- Supporting clinical documentation

Consider keeping on hand a copy of the most current E/M coding guidelines (from AMA and/or CMS) to submit with any appeals. CPT Network (available to AMA members and subscribers) can be another valuable resource when submitting appeals to health plans. Also, to ensure that payers refer to the proper place in the submitted documents, it is a good idea to highlight the relevant assessment or plan in the clinical documentation being used to support your appeal.

Sometimes payers include physicians in global prepayment review programs, which expose all of the physician's claims to automatic downcoding. If you think you have been subject to such a program, you will need to appeal your inclusion on the payer's downcoding list. A good place to start is to reach out to the health plan's provider representative. To be removed from the program, you might need to submit documentation for several claims to demonstrate a pattern of correct coding.

V. DOCUMENTATION TO PREVENT AND FIGHT DOWNCODING: THE BEST DEFENSE IS A STRONG OFFENSE

Supporting documentation is crucial to a successful appeal. Furthermore, knowing the fee schedule, keeping up with best coding practices, and maintaining thorough and systematic documentation practices is the best strategy to avoid payer downcoding that is done based on a review of the medical record.

The medical record should closely 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. For office and other outpatient services, level of service is determined by degree of MDM **or** total time spent on the date of the encounter.

A. E/M leveling based on MDM

MDM refers to the process of making a diagnosis, assessing the status of a condition, and/or selecting a management option. There are 4 levels of MDM: straightforward, low complexity, moderate complexity, and high complexity. For office or other outpatient service codes, MDM is determined by meeting the stated requirements on **two out of three** of the following elements:

1. **The number and complexity of the problems addressed during the encounter** (i.e., number of possible diagnoses and/or management options that must be considered)
2. **The amount and/or complexity of data to be reviewed and analyzed** (including medical records, diagnostic tests, independent interpretation of tests, and discussion of management or test interpretation with other appropriate health care professionals)
3. **The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit**, associated with the patient's problem(s), the diagnostic procedure(s), and treatment(s).[1],[2]

Here are E/M CPT codes commonly involved in downcoding, along with the MDM and time requirements associated with each code:

New Patient E/M Visits

CPT	MDM Level	Time
99202	Straightforward	15–29 min
99203	Low complexity	30–44 min
99204	Moderate complexity	45–59 min
99205	High complexity	60–74 min

Established Patient E/M Visits

CPT	MDM Level	Time
99212	Straightforward	10–19 min
99213	Low complexity	20–29 min
99214	Moderate complexity	30–39 min
99215	High complexity	40–54 min

Table I: Documentation for MDM-based E/M coding

The table below provides an overview of the CPT Coding Guidelines for straightforward, low, moderate, and high MDM Levels across all three elements. It also provides some key items to document when determining the appropriate level of MDM, as recommended by 2022 CMS educational materials. **The table is not intended to be a comprehensive resource for E/M coding.** Please consult the CPT coding guidelines and other AMA resources for more information on how to determine level of MDM.

1. See CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202–99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes
2. See also CMS Medicare Learning Network Evaluation and Management Services Guide

Documentation for MDM-based E/M Coding

1. Number and Complexity of Problems Addressed

<table>
<tr><th>Level of MDM</th><th>CPT Guidelines/Criteria[3]</th><th>CMS Documentation Recommendation[4]</th></tr>
<tr><td>Straightforward
(CPT 99202, 99212)</td><td>Minimal
1 self-limited or minor problem</td><td rowspan="4">To demonstrate number and complexity of problems addressed, CMS recommends documenting:
• An assessment, clinical impression, or diagnosis for each encounter
• The initiation of, or changes in, treatment, including all management options (such as patient instructions, nursing instructions, therapies, and medications)
• Any diagnostic tests performed (and not separately reported)
• Worsening problems or problems that are failing to change as expected
• Any referrals made, consultations requested, or advice sought from other clinicians
• Notes on the MDM process (not just the decision)
• Secondary diagnoses that impact MDM</td></tr>
<tr><td>Low
(CPT 99203, 99213)</td><td>Low
2 or more self-limited or minor problems;
or
1 stable chronic illness;
or
1 acute, uncomplicated illness or injury</td></tr>
<tr><td>Moderate
(CPT 99204, 99214)</td><td>Moderate
1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
or
2 or more stable chronic illnesses;
or
1 undiagnosed new problem with uncertain prognosis;
or
1 acute illness with systemic symptoms;
or
1 acute complicated injury</td></tr>
<tr><td>High
(CPT 99205, 99215)</td><td>High
1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
or
1 acute or chronic illness or injury that poses a threat to life or bodily function</td></tr>
</table>

3. See CPT E/M Office Revisions Level of Medical Decision Making (MDM)
4. See CMS Medicare Learning Network Evaluation and Management Services Guide, January 2022

2. Amount and/or Complexity of Data to be Reviewed and Analyzed

<table>
<tr><th>Level of MDM</th><th>CPT Guidelines/Criteria</th><th>CMS Documentation Recommendation</th></tr>
<tr><td>Straightforward
(CPT 99202, 99212)</td><td>Minimal or none</td><td rowspan="3">To demonstrate amount and/or complexity of data to be reviewed and/or analyzed, CMS recommends documenting:
• Any diagnostic services ordered (not separately reported)
• Decisions to review old medical records or obtain history from sources other than the patient, and relevant findings
• Discussions of contradictory or unexpected test results with the physician who performed or interpreted the test
• The direct visualization and independent interpretation of an image, tracing, or specimen previously interpreted by another physician
• Review of laboratory, radiology, and other diagnostic tests (not separately reported)</td></tr>
<tr><td>Low
(CPT 99203, 99213)</td><td>Limited
(Must meet the requirements of at least 1 of the 2 categories)

Category 1: Tests and documents
Any combination of 2 from the following:
• Review of prior external note(s) from each unique source;
• review of the result(s) of each unique test;
• ordering of each unique test

or

Category 2: Assessment requiring an independent historian(s)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td></tr>
<tr><td>Moderate
(CPT 99204, 99214)</td><td>Moderate
(Must meet the requirements of at least 1 out of 3 categories)

Category 1: Tests, documents, or independent historian(s)
Any combination of 3 from the following:
• Review of prior external note(s) from each unique source;
• Review of the result(s) of each unique test;
• Ordering of each unique test;
• Assessment requiring an independent historian(s)

or

(Continues)</td></tr>
</table>

<table>
<tr>
<td>Moderate
(CPT 99204, 99214)
(Continued)</td>
<td>Category 2: Independent interpretation of tests
• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

or

Category 3: Discussion of management or test interpretation
• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
<td rowspan="2">To demonstrate amount and/or complexity of data to be reviewed and/or analyzed, CMS recommends documenting:
• Any diagnostic services ordered (not separately reported)
• Decisions to review old medical records or obtain history from sources other than the patient, and relevant findings
• Discussions of contradictory or unexpected test results with the physician who performed or interpreted the test
• The direct visualization and independent interpretation of an image, tracing, or specimen previously interpreted by another physician
• Review of laboratory, radiology, and other diagnostic tests (not separately reported)</td>
</tr>
<tr>
<td>High
(CPT 99205, 99215)</td>
<td>Extensive
(Must meet the requirements of at least 2 out of 3 categories)

Category 1: Tests, documents, or independent historian(s)
Any combination of 3 from the following:
• Review of prior external note(s) from each unique source;
• Review of the result(s) of each unique test;
• Ordering of each unique test;
• Assessment requiring an independent historian(s)

or

Category 2: Independent interpretation of tests
• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

or

(Continues)</td>
</tr>
</table>

High (CPT 99205, 99215) *(Continued)*	**Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	*(See above)*

3. Risk of Complications and/or Morbidity or Mortality of Patient Management

Level of MDM	CPT Guidelines/Criteria	CMS Documentation Recommendation
Straightforward (CPT 99202, 99212)	**Minimal risk of morbidity from additional diagnostic testing or treatment**	To demonstrate risk of complications and/or morbidity or mortality of patient management, CMS recommends documenting: • Comorbidities/underlying diseases or other factors that increase complexity of MDM by increasing risk of complications, morbidity, and/or mortality • If a surgical or invasive diagnostic procedure is performed at the time of the E/M, the type and specific procedure • The referral for or a decision to perform a surgical or invasive diagnostic procedure on an urgent basis
Low (CPT 99203, 99213)	**Low risk of morbidity from additional diagnostic testing or treatment**	
Moderate (CPT 99204, 99214)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	
High (CPT 99205, 99215)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis	

B. E/M leveling based on time

As an alternative to MDM, time spent on the date of the encounter can be used as a basis for E/M leveling. The table below provides some tips for what to include and document when determining time spent for E/M leveling purposes.

Documentation for Time-based E/M Coding[5]

Include and Document	Do NOT Include
Total time spent on the day of the encounter, including: ✓ Preparing to see the patient ✓ Reviewing history ✓ Performing a medically appropriate exam or evaluation ✓ Counseling and educating patient/family/caregiver ✓ Communicating with other health care professionals or making referrals ✓ Documenting clinical information ✓ Interpreting and communicating test results (not separately reported) ✓ Care coordination (not separately reported) **Face-to-face and non-face-to-face time spent on the same day of the visit, before, during and after the visit** **For split/shared visits, non-physician qualified health care professional time**	✗ Time spent on a calendar day other than the day the patient was seen ✗ Time spent performing services that are reported separately ✗ Time spent ordering tests when the interpretation of those tests is reported separately ✗ Time spent in conversation unrelated to the medical visit ✗ Travel ✗ Time spent by clinical staff ✗ Time spent on teaching that is general and not limited to discussion required for the management of a specific patient

Consult AMA resources for more information on determining level of MDM and other documentation tips for E/M.

5. See Office or Other Outpatient (99202–99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes

VI. AMA POLICY ON DOWNCODING

The AMA believes that many current payer downcoding practices do not accurately reflect the updated E/M guidelines and/or may inappropriately use diagnosis codes as a proxy for the level of care provided. In addition, automatic downcoding programs place onerous administrative burdens on practices forced to fight for appropriate payment rates. When it comes to downcoding programs, AMA advocates according to the following principles:

Outliers only: The AMA does not support blanket downcoding initiatives. Any downcoding program should *only* target true outlier physicians whose coding patterns differ significantly from that of their same-specialty peers and should never be bluntly applied to all physicians.

Education first: For those few physicians identified as having outlier coding patterns, payers should first employ an **educational approach** and reach out to the practice with correct coding information and instructional materials. This is often an effective and sufficient way to address any coding practices that appear "improper."

Review of the medical record: The AMA maintains that it is never appropriate to downcode claims automatically or without a review of the medical record. In the few instances where a claim is subject to downcoding, the physician should have an opportunity to provide supporting documentation *before* payment is reduced, not after. *(Note: it is unduly burdensome to require that documentation be provided routinely for all claims the payer deems potentially subject to downcoding; as such, medical record reviews should be limited to true outliers.)*

Prior notification: While the AMA does not support automatic downcoding, any physician subject to an automatic or algorithm-based downcoding program should be notified in advance of the downcoding so they know to be on alert for downcoded claims.

Clear communication: The AMA does not support unilateral downcoding; however, any payer that does downcode a claim should send the physician written notification of the adjustment, including the principal reason the claim was downcoded, specific clinical rationale for the decision, and a statement describing the process for appeal. Further, to support practices in conducting accurate coding audits, if payment is adjusted, then the corresponding code should be adjusted accordingly, and clear remittance advice should be provided.

If your practice has been subject to payer downcoding, please consider completing this AMA informational survey. Results will be used to help support physician practices in responding to payer downcoding initiatives.

APPENDIX: SAMPLE APPEAL LETTER FOR INAPPROPRIATE E/M DOWNCODING

E/M downcoding sample letter

[Date]
Attn: [Name]
Provider Appeals Department
[Address]
[City, State, ZIP Code]

Re: Inappropriate downcoding of CPT evaluation and management (E/M) code

Insured/Plan Member: [Name]
Member Identification Number: [Number]
Group Number: [Number]
Patient Name: [Name]
Claim Number: [Number]
Claim Date: [Date]

Dear [Health Insurer]:

On the date of service listed above, the CPT E/M code for [a/an] [name of service] was reported with [CPT code]. [Health insurer] has inappropriately downcoded the CPT E/M code submitted and changed the code to [new code], resulting in the inappropriate reduction of payment for delivered medical care.

Under [health insurer] medical review guidelines, [health insurer] follows the 2021 CMS E/M coding guidelines. [Physician name] has billed according to the 2021 CMS E/M guidelines accurately.

Downcoding of CPT E/M codes is not appropriate without review of medical record documentation. The American Medical Association (AMA) strongly opposes automatic downcoding and states:

"The AMA vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers."

The appropriateness of the reported level of the CPT E/M [CPT code] is clearly documented within the patient's chart (attached) and should be recognized by [health insurer]. Based on the circumstances of this case, we are requesting that CPT E/M code [code] be paid and not be inappropriately downcoded.

Thank you for your reconsideration. Please contact [contact name] at [telephone number] in our office should you have any questions regarding this claim.

Sincerely,

[Physician]

Or

[Practice Manager]

Procedure downcoding sample letter

[Date]
Attn: [Name]
Provider Appeals Department
[Address]
[City, State, ZIP Code]

Re: Inappropriate downcoding of CPT procedure code

Insured/Plan Member: [Name]
Member Identification Number: [Number]
Group Number: [Number]
Patient Name: [Name]
Claim Number: [Number]
Claim Date: [Date]

Dear [Health Insurer]:

On the date of service listed above, the CPT code for [a/an] [name of procedure] was reported with [CPT code]. [Health insurer] has inappropriately downcoded the CPT code submitted and changed the code to [new code and name of procedure], resulting in the inappropriate reduction of payment for delivered medical care.

Downcoding of CPT codes is not appropriate without review of medical record documentation. The American Medical Association (AMA) strongly opposes automatic downcoding and states:

"The AMA vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers."

The level of complexity for the procedure performed CPT [code] was reported appropriately and is clearly documented within the patient's chart (attached) and should be recognized by [health insurer]. Based on the circumstances of this case, we are requesting that CPT code [code] be paid and not be inappropriately downcoded.

Thank you for your reconsideration. Please contact [contact name] at [telephone number] in our office should you have any questions regarding this claim.

Sincerely,

[Physician]

Or

[Practice Manager]

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