



What To Know About Payers' Downcoding Procedures

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Insurers are drawing provider backlash for new payment policies that reduce reimbursements. For example, Cigna is automatically “downcoding” 6 evaluation and management (E/M) billing codes for a small percentage of providers, resulting in lower payments for routine services like office visits. Aetna’s new Medicare Advantage policy will automatically approve certain hospital admissions but reimburse them at the lower observation rate instead of the full inpatient rate. Providers argue these opaque methods increase administrative costs and lead to underpayment.

Implications for Urgent Care Centers

The new Cigna downcoding policy has a direct and negative impact on urgent care centers.

- **Lower revenue for core services:** Urgent care primarily manages acute, low-to-moderate complexity conditions, which correspond to the E/M codes Cigna is targeting. If an urgent care center is flagged as an “outlier,” a significant portion of its routine claims will be automatically downcoded, directly reducing its total revenue per visit.
- **Increased administrative burden:** Being downcoded forces the urgent care center to dedicate more staff time and resources to appealing the payment for the higher original code. This adds significant administrative cost without a guarantee of success, effectively reducing the net profit per claim even further.
- **Pressure to code lower:** The policy creates a financial disincentive for providers to bill for the actual complexity of the patient’s visit, potentially leading to inaccurate billing practices or insufficient documentation efforts to meet the insurer’s demands, rather

than clinical necessity.

While the Aetna policy is less relevant, Cigna’s downcoding is a direct threat to the financial viability and operational efficiency of urgent care centers that rely on accurate E/M coding for their primary revenue stream.

BCBS Downcoding

Similarly, several individual Blue Cross Blue Shield (BCBS) licensees (eg, Illinois, Texas, and Massachusetts) have acknowledged that they will change, recode and/or downcode a claim to a lower payment code in certain situations, particularly for No Surprises Act (NSA) or nonparticipating provider claims.

BCBS will assess level 4 and 5 E/M codes to determine if the level of service billed is appropriate for the severity of the member’s condition as reported on the claim. Consideration will include but will not be limited to current claim information and member claim history. For emergency department visits, information on the corresponding facility claim that may identify resources used as part of the visit (labs, radiology, pharmaceuticals, etc.) will be considered.

If an E/M code is determined to be overcoded, the insurer may adjust reimbursement from level 5 E/M code/reimbursement to level 4 or 3, and level 4 E/M code/reimbursement to level 3. If the provider disagrees with a determination, they may submit supporting documentation to support the higher level of care.

When Blues plans recode, they usually notify the provider on the claim summary and explain why the code was changed.

An urgent care’s best action is to bill for E/M services in accordance with American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) guidelines. BCBS recognizes the 2021 and 2023 AMA code selection and reporting guidelines for E/M services, which replace CMS 1995 and 1997 documentation guidelines. BCBS also recognizes the 2021 AMA code selection guidelines for outpatient office visit codes CPT 99202-99215. ■



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