

# Downcoding and Bundling of Claims: What Physicians Need to Know About These Payment Problems

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## Introduction

Coding can be a confusing issue for a physician practice. If it isn't done properly, payment for services can be denied or significantly reduced. On the other hand, even though a physician practice often does everything correctly when it comes to coding, payments may still be denied, delayed, and/or significantly reduced by health insurers.

The bottom line is that physicians are entitled to be paid for the services they provide. The first step in assuring that this occurs is to make sure that each and every claim is submitted correctly. This means that the correct code is selected to describe the services rendered and that any other requirements of the insurer are met.

Even after jumping through the hoops, physicians cannot control what happens to the claims once those claims leave a physician's office. A whole slew of problems can occur and are responsible for millions of dollars in lost income annually. The purpose of this supplement is to explain the terminology used in coding and claims submission, help physicians understand the importance of coding correctly, alert physicians to some of the increasingly common health insurer tactics that undermine physicians' efforts to get fair compensation for services rendered, and propose possible solutions.

At the outset, it is important for physicians and their office staff to understand the difference between what they may perceive as a coding problem and what is, in fact, a payment policy problem. Health insurers are free to set their own

payment policies, which is why it is important for physicians to know fee schedule amounts.

This paper addresses problems relating to commercial insurance and does not address claims and coding issues in the Medicare program.

## What is CPT?

Current Procedural Terminology (CPT®), a coding work, was developed by the American Medical Association (AMA) and organized medicine over 30 years ago and is the most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs. It is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. CPT currently includes over 7800 codes. The development of CPT continues to be driven by the need for accurately reporting medical services, which benefits patients, physicians, and payors alike.

## How is CPT kept current?

CPT is kept current through the CPT Editorial Panel process. The CPT Editorial Panel is made up of 16 members, including 11 physicians nominated by the AMA, the chair of the Health Care Professionals Advisory Committee (HCPAC), and one physician representative each nominated by the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the American Hospital Association,

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and the Centers for Medicare and Medicaid Services. The CPT Editorial Panel is supported in its efforts by the CPT Advisory Committee, which is made up of representatives of more than 100 national medical specialty societies and other health care professional organizations.

CPT is maintained and routinely revised, updated, and modified to address the often complex problems associated with new technologies, outdated medical procedures, and changes in medical care. The CPT Editorial Panel addresses over 60 major topics a year, which typically involve more than 3000 votes on individual items. The panel actions result in three outcomes:

- 1) add a new code or revise existing nomenclature;
- 2) table an item for further discussion;
- 3) reject an item.

The AMA implements the decisions and recommendations of the CPT Editorial Panel.

### **Are health insurers required to abide by the CPT guidelines and instructions?**

The AMA holds a copyright to CPT codes and descriptions as well as its guidelines, notes, and instructions. Use or reprinting of CPT materials in any product or publication requires a license, unless the use is very limited and would be “fair use” as defined in the U.S. copyright laws. CPT is widely licensed to software developers, medical publishers, and others who are interested in using CPT codes or descriptions to describe medical procedures. The law does not permit the AMA to enforce certain payment policies based on a payors’ interpretation of CPT. In other words, the CPT Editorial Panel controls CPT issues,

while private health insurers largely control payment policy.

CPT is designed to be used in its entirety. The structure of the coding system provides precise definitions and instructed usage for each service or procedure subject to a separate code. The AMA also requires CPT licensees to use commercially reasonable steps to follow CPT guidelines, notes, and instructions for use of CPT (as included in the current CPT book) in the development and updating of their products.

The AMA succeeded in having CPT named as the code set for physician services in the Administrative Simplification Rules on Transactions and Code Sets promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This was a great success for physicians and means that by October 2003, all providers and insurers who transmit health care information must be able to read and accept CPT codes and modifiers. However, the AMA did not succeed in having the CPT guidelines named as the national standard. Had the AMA succeeded, this would have addressed the concerns of physicians about varying interpretations of CPT by insurers. The AMA needs the strong support of physicians and others to work towards the eventual adoption of the CPT guidelines as a standard under federal law.

Acceptance of CPT codes, guidelines, and conventions does not imply standardized payment for documented and reported services. However, the increasingly arbitrary, unilateral, and inconsistent application of CPT codes, guidelines and conventions has created confusion and uncertainty for physicians and made it difficult—if not impossible—to determine whether the health insurer has paid according to the contracted rate.

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## Downcoding and Bundling Claims, *continued*

It is important for physicians to understand that nothing prevents the federal government or any private health insurer from choosing another code set over CPT in the future. This code set could be introduced by groups far removed from hands-on patient care.

Physicians should never take CPT for granted. The path the AMA chooses and the steps taken to enhance CPT will largely determine whether organized medicine is able to continue to lead in the development of medical service coding, not only for physicians, but for the entire health care industry.

### **Is CPT a reimbursement system?**

No. The CPT process to develop codes and descriptions does not dictate the payment amount or whether or not a service is covered under any particular payment program. CPT merely represents a language or communication methodology for claims submission for services and procedures. However, increasingly, commercial insurance payment systems are based on a Medicare Resource-Based Relative Value System (RBRVS) or some other relative value system, which establishes physicians' work values for CPT codes based on their precise definitions and instructed usage.

When Medicare implemented the RBRVS in 1992, the CPT Editorial Panel (which includes representatives from the Blue Cross and Blue Shield Association and the Health Insurance Association of America) agreed with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) that modifiers were crucial in establishing a formalized structure and linkage between CPT coding and this new payment methodology. When health

insurers base payment on the Medicare RBRVS, it is particularly inappropriate for these health insurers to misapply CPT coding and justify denial of payment based on this misapplication.

### **How exactly does CPT coding relate to claims billing?**

CPT is an integral part of claims billing. As noted, CPT provides a common "language" for physicians to submit claims to health insurers. Each claim submitted for services provided or procedures performed must include:

1. An ICD-9-CM diagnosis code to describe the diagnosis or symptoms for which a service or procedure was provided. A HCFA 1500 claim form typically allows multiple CPT codes to be linked to a single ICD-9-CM diagnosis code;
2. The correct CPT code(s) for each service and/or procedure provided;
3. With unlisted procedures, appropriate supporting documentation.

### **What are the keys to accurate documentation for claims submission?**

It is AMA policy that the medical record is first and foremost a clinical record to support patient care. Nonetheless, accurate documentation plays a critical role in claims submission. Physicians should assure that the medical record supports the need for the level of service billed and the procedures or services provided. Accurate medical records should be maintained to reflect all pertinent information, including diagnoses, clinical findings, tests ordered, and procedures performed. Any consultations over the phone also must be documented.

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The medical record comes into play in at least two situations relating to claims submission. First, if physicians believe claims were wrongly denied (or bundled/downcoded), accurate documentation in the medical record will be a key component to any appeal. Second, if physicians are retroactively audited by a health insurer or are accused of fraud, the medical record will be an important defense.

Some health insurers are following the example of the Medicare program and requiring supporting documentation for certain levels of evaluation and management (E/M) services. This will be touched on briefly in the “downcoding” section. All of this highlights the importance of accurate medical records documentation.

### **How does the managed care contract impact claims submission?**

Contracts between physicians and health insurers set forth, or should set forth, detailed information on how claims should be submitted, including the following: the type of patient information required, the type of form to use (almost universally the HCFA 1500 form), the type of documentation required, and the place to send the information.

Physicians should beware of contract terms that state that CPT will be used for claims submission, but add a caveat such as “the Company reserves the right to rebundle to the primary procedure those services determined by the Company to be part of, incidental to, or inclusive of the primary service.” This type of provision is designed to permit the health insurer to engage in the objectionable practices described in this article.

### **What is “bundling” of claims?**

In the broadest sense, “bundling” occurs when a physician submits a claim for two or more separate and distinct CPT services or procedures performed on a single patient during a single office visit and the insurer “bundles” them together and reimburses for just one of the services or procedures, typically the one of lowest cost. This happens in a variety of ways. The most common are through ignoring CPT modifiers and through the use of secret “black box” edits.

- **Ignoring modifiers**

One of the most common ways of bundling is for health insurers to ignore CPT modifiers.

A CPT modifier is an additional two-digit code reported together with a CPT code that indicates that the procedure or service was somehow modified. There are several modifiers whose purpose is to signal to the health insurer that two or more services or procedures submitted on a single claim and performed on the same day are, in fact, separate and distinct and separately reimbursable. The problem of claims “bundling” occurs when an insurer ignores the modifier, “bundles” the two reimbursable procedures together, and reimburses only for one. This results in an unfair devaluation of the physician’s services.

Physician complaints about health insurers ignoring modifiers and bundling separate procedures and services occur most frequently with modifier -25.<sup>1</sup> Modifier -25 is described in the CPT Manual as a “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.”

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<sup>1</sup> The AMA also has received complaints about modifiers -51, -57, and -59 being inappropriately ignored, and separate procedures “bundled.”

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## Downcoding and Bundling Claims, *continued*

In simpler terms, modifier -25 is used when a patient presents with one health care problem that a physician evaluates, manages, and treats, and during the same visit the patient also presents a second unrelated problem that the physician treats. Modifier -25 also can be used when the patient's condition required a significant, separately identifiable Evaluation and Management (E/M) service **above and beyond** the usual preoperative and postoperative care associated with the procedure that was performed. That work takes additional physician time and resources and should be reimbursed. However, health insurers frequently ignore modifier -25 and reimburse for just one service (the lowest cost). It is also important to note that the diagnosis reported with both the procedure/service and E/M service need not be different, if the same diagnosis accurately describes the reasons for the encounter and the procedure.

Health insurers ignore modifier -25 (and other modifiers) to save money. Because it is done automatically, there is no consideration of the actual clinical encounter between the patient and physician. This is directly contrary to published CPT instructions and violates principles of fundamental fairness. Physicians should not be penalized for providing all necessary care during a single office visit, and, instead, insurers should reward this efficiency and quality care.

- **“Black box” edits**

**A second common form of bundling is through “black box” coding edits.** “Black box” edits refer to claims editing software that health insurers purchase and then customize to automatically ignore certain modifiers or to group certain CPT codes together in a manner contrary to CPT instructions. The term black box comes from the fact that health insurers consider these

edits proprietary and keep them secret. The physician typically is reimbursed for just one procedure and receives no reimbursement for the second procedure.

Black box edits are very problematic because of the secretive nature of the edits. For example, some third-party vendors will customize surgical “packages” for health insurers’ billing purposes. What services or procedures are included in the package are often unknown and may not be consistent with CPT. Moreover, there are any number of idiosyncratic edits that are difficult to even decipher from an explanation of benefit (EOB) form. Sometimes physicians can figure out certain edits after getting numerous denials or lower reimbursement for the same service or procedure, but this is still difficult.

It is particularly troubling that commercial health insurers insist on using secret “black box” edits, in light of the Centers for Medicare and Medicaid Services’ (CMS) decision to eliminate black box edits in the Medicare program and make all coding edits public. While CMS’s approach to the issue of coding edits is not perfect, this new policy acknowledges and respects that physicians have a basic right to know coding policies and procedures before claims submission.

CMS also has solicited the AMA and national medical specialty societies for input into matters relating to coding edits through the Correct Coding Policy Committee. Through this process, the national medical specialty societies have reviewed and submitted comments on tens of thousands of proposed edits to CMS. CMS has reconsidered some proposed edits as part of this process. Commercial health insurers, in contrast, have shown little interest in eliminating “black box” edits or in seeking outside physician input

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as to the clinical justification for these arbitrary edits.

### **How does a physician practice determine that bundling is occurring?**

If a physician practice suspects that inappropriate bundling is occurring, office staff must pay close attention to EOB forms. The original claims submission must be compared to the EOB form. If the health insurer is ignoring modifier -25 (or other modifiers) and bundling the two claims or using a claims editing software to otherwise “bundle” the claims, the EOB form will not necessarily reflect this.

Instead, the EOB form typically will indicate that there was no payment for the initial office/outpatient visit and a payment for the separate, secondary procedure. In some cases, under the “adjustment code description” or the “remarks” section of the EOB, an ambiguous reason for non-payment will be given such as “when you report multiple related services on the same day for a patient, insurer bases benefit payment on the primary service,” or “denied; this procedure is included in the global services.”

### **Is “partial payment” of multiple claims a form of “bundling”?**

No. What is referred to as “partial payment” of multiple claims occurs when a practice submits claims for multiple procedures. Rather than bundling the CPT codes, the health insurer will recognize all codes, pay 100% of the first claim, then progressively reduce amounts for the second and third claims, sometimes paying as little as 25% per claim. The insurer’s rationale is that the

second and third procedures are components of the first claim, and therefore should be reimbursed at a lower level. In some circumstances, Medicare also pays progressively less for these same “components,” but Medicare typically reimburses at a significantly higher level for the second and third claim.

While partial payment is another key reimbursement issue that the AMA Private Sector Advocacy Group is exploring, it is not explored in detail in this analysis because it is a separate and distinct problem from bundling and downcoding claims.

### **What is “downcoding” of claims?**

“Downcoding” occurs when a health insurer unilaterally reduces an E/M service level. The typical scenario occurs when a practice submits a claim for a patient visit based on a CPT code definition (for example, new patient visit code 99204—a “level 4”) and the insurer automatically “downcodes” the claim to a lower level (for example, new patient visit code 99203—a “level 3”) and then reimburses at a lower rate. Typically, the physician receives no explanation for the change but simply receives lower reimbursement. Occasionally the EOB form might include an ambiguous explanation such as “level of service (or procedure) has been adjusted” but more typically the only way to detect that downcoding occurred is to be familiar with the fee schedule and compare that to the amount received on the EOB form.

Sometimes health insurers downcode based solely on the diagnosis code. In other words, the insurer assumes (most likely through a software system) that when a patient presents with certain

diagnoses, the clinical evaluation can never be more complicated than a certain E/M level, regardless of the specifics of the individual case. This assumption has no clinical basis. In order to appeal the decision, the practice is stuck with the administrative burden of having to submit additional justification for the level of service performed.

A new twist on downcoding involves additional documentation requirements for some E/M services. This has appeared in two forms, with some health insurers either: 1) adopting a policy that all level 4 and 5 claims will automatically be downcoded, and then physicians will have a window of time to submit additional documentation to support the claim; or 2) requiring substantial additional documentation for all level 4 and 5 claims initially. In addition to the administrative burden, these requirements can complicate physician efforts to file claims electronically.

Moreover, requiring all physicians to provide substantial additional documentation does not further the alleged goal of the health insurers, which is to identify physicians who overuse these codes without clinical justification. Instead, it penalizes physicians across the board, particularly those with a sicker, more complex patient mix, and seems designed to save money. The AMA has successfully worked with the Federation to advocate with some insurers that they pull back and place limits on these documentation requirements.

The practice of downcoding claims is another important reason for physicians to assure that the medical record supports the level of services reflected in the claim. Any appeal of a claim that has been downcoded will require submission of supporting documentation from the medical

record. CMS has developed detailed guidelines to provide physicians and claims reviewers with advice about preparing or reviewing documentation for E/M services in the Medicare program. While these guidelines are specific to Medicare, some private payors use them, and they are one resource for physician office staff. To the extent the medical record complies with these guidelines, it should be a very strong argument in support of the physician's position. Those guidelines are available on the Internet at <http://cms.hhs.gov>.

### **Why do insurers bundle and downcode?**

Bundling and downcoding save money for health insurers, ultimately bolstering their bottom lines. However, the justifications actually used by insurers are questionable. For example, insurers may contend that these practices further their efforts to identify cases of fraud and abuse. The AMA is absolutely opposed to any true acts of fraud and abuse committed by physicians or other health care providers. However, automatically bundling and downcoding does nothing to further the elimination of fraud and abuse because it does not result in identifying or punishing true offenders. Instead, it penalizes all physicians.

Health insurers also contend that some of the software edits that bundle and downcode claims are due to the preferences and benefit packages developed for employers. This "passing the buck" makes it that much more difficult for physicians to get to the root of the problem.

Regardless of the justification, systematic bundling and downcoding of claims without reviewing supporting documentation goes against

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the entire definitional structure of the CPT system, which provides precise definitions and instructed usage for each service or procedure subject to a separate code. With the increasing reliance on Medicare RBRVS-based payment systems, arbitrarily ignoring CPT instructions undermines the concepts of uniformity and fairness in payment systems.

### **Does the AMA have policy relating to bundling and downcoding of claims?**

Yes. The AMA has policy strongly opposing these practices. These policies can be accessed at the AMA web site (<http://www.ama-assn.org>).

### **How can physicians work with the AMA Private Sector Advocacy (PSA) unit to fight bundling and downcoding?**

The AMA's Private Sector Advocacy (PSA) unit stands ready to assist state and county medical associations and national medical specialty societies where patterns of inappropriate bundling and downcoding of claims are identified. There are two key components to building an argument that a health insurer is inappropriately bundling or downcoding.

- 1. Documentation of a pattern in a particular locale with a particular health insurer:** PSA is working with medical societies to help them gather information to determine if the problem is widespread. This includes collecting the original claims submission, the explanation of benefits (EOB), and any appeals or other communication between the physician and the insurer. Effective advocacy will require collecting enough of these examples to show a

pattern. These examples must be reviewed for coding and other possible claims submission errors.

- 2. Developing the clinical and policy-based reasons to counter the health insurer's justification for bundling or downcoding:** There are a number of ways to do this. Probably the most important is to explain why, from a clinical standpoint, one service or procedure should not be considered a component of another service or procedure. This requires a detailed explanation of the nature of the service or procedure. This is where the assistance of the appropriate national medical specialty societies is critical.

From a policy standpoint, there are several approaches that can bolster an argument that the bundling or downcoding is inappropriate. First, evidence that the health insurer does pay for each procedure when performed on separate visits should be gathered. Second, evidence that other insurers in the area do not bundle or downcode in this manner also should be gathered.

Once the information is gathered and arguments developed, the problem should be brought to the attention of the health insurer. As with all issues, in scheduling a meeting, it is important that the medical society insist that individuals with decisionmaking authority at the insurer or health plan attend, as well as the plan's regional medical director. If the insurer or health plan blames an employer, the medical society should indicate that it plans to follow-up with the employer, and should do so.

The AMA is willing to assist medical societies at any step in the process, including attending meetings with the health insurer.

**What can individual medical practices do about the problems of bundling and downcoding?**

By far the most important first step is to assure that the physician's office staff is coding claims correctly, including providing all supporting documentation. Physician office staff must have a clear understanding of and comply with the health insurer's claims submission process. This information should be set forth in the managed care contract or provider manual. If the information is not provided, physicians should be aggressive in requesting it.

There are a wide range of tools available to assist practices in coding correctly, including a number of publications and workshops available through the AMA at <http://webstore.ama-assn.org/index.jhtml>. For example, the AMA CPT Information Service (CPT-IS) is a coding help-line offered by the AMA. AMA members receive their first four CPT-IS inquiries each year free of charge. Specialists are available Monday through Friday, 9:00AM to 4:45PM CST, to handle inquiries ranging from simple interpretation of CPT guidelines to complete coding of the most complex operative reports.

In addition, a number of state medical associations have correct coding initiatives to educate physicians about coding claims correctly. If a physician believes that there may be problems with the way staff are coding claims, it may be worthwhile to bring in a consultant to review the process and educate the staff.

Physician practice staff also must be vigilant in reviewing insurer EOB forms to determine

whether bundling and/or downcoding are occurring. Payment received routinely should be compared to the fee schedule (if provided) to make sure correct payment has been provided.

If a claim is filed correctly and the health insurer inappropriately bundles or downcodes, the physician should attempt to appeal the claim, by putting in writing a clinical justification for the appeal. The practice should document all communication with the insurer. While appealing claims obviously adds another administrative burden to the practice, there is a large element of truth in the "squeaky wheel" theory: an individual physician who is persistent, has good documentation, and is logically persuasive stands a better chance at succeeding than a physician who does nothing.<sup>3</sup>

The physician also should notify the relevant state and county medical associations and the relevant national medical specialty society. Those entities can then determine how widespread the problem is, and, if it is widespread, work with the AMA to develop an advocacy strategy. Finally, physicians should complete the AMA Health Plan Complaint Form, which can be accessed at [www.ama-assn.org/go/psa](http://www.ama-assn.org/go/psa). That information will be used to determine prevalence of these practices.

**A note on electronic filing of claims**

One important step toward simplifying the claims submission process and reducing the possibility of error or delayed claims is establishing a system to file claims electronically. This should be a

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<sup>3</sup> In 2002, an Illinois physician settled a lawsuit with a large national insurer, which paid him \$145,000 for late claims as well as

downcoded claims. The physician kept impeccable claims records, which put him in a strong position in settlement negotiations.

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top priority for physicians and their practice administrators for a number of reasons. Electronic claims generally are paid much quicker than paper claims, and, if there are problems with the claim, refiling is significantly easier. And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires electronic claims submission for most physicians as of October 2002, unless the physician or physician practice has filed for a one-year extension. The sooner physicians make this transition, the fewer headaches in the future.

## **Conclusion**

Physicians face a wide array of problems getting paid for the services they provide their patients, from getting paid on time, to getting paid at all. The practices outlined here are just a few of the methods health insurers use to deprive physicians of full payment for services rendered. The AMA and its Private Sector Advocacy unit stand ready to combat abusive practices that no other legitimate business concerns would tolerate and that interfere in physicians' ability to provide quality patient care.