Whereas, in recent years there has been a sharp increase in health plans using third-party software, algorithms, artificial intelligence, or some other automated process to deny or downcode evaluation and management (E/M) service levels based solely on the diagnosis code(s), Current Procedural Terminology/Healthcare Common Procedure Coding System code(s), or modifiers submitted on a claim; and

Whereas, a review of the medical record is necessary to determine if the E/M service level billed should be denied or downcoded; and

Whereas, these software programs and algorithms should not be used as the sole determinant of E/M service level denials or downcoding; and

Whereas, the explanation of benefits, remittance advice documents, or other claim adjudication notices do not provide the physician notice that a service was downcoded; therefore be it RESOLVED, that our American Medical Association vigorously oppose health plans exclusively relying on software, algorithms, or other methodologies excluding review of the patient’s medical record to deny or downcode evaluation and management services, other than correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, and/or modifiers submitted on the claim (New HOD Policy); and be it further RESOLVED, that our AMA support that, after review of the patient’s medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes (New HOD Policy); and be it further RESOLVED, that our AMA advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim (Directive to Take Action); and be it further RESOLVED, that our AMA further evaluate what legislative and/or legal action is needed to prevent insurers from automatic downcoding and to provide transparency on all methodology of processing claims. (Directive to Take Action)
Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/10/2024

REFERENCES

RELEVANT AMA POLICY

H-70.937 Bundling and Downcoding of CPT Codes
Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers; (2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards; (3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and (4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers. [Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17]