



MEMO

Date: October 8, 2025

To: All Providers, APPs, Clinical Staff, Scheduling, Billing & Coding

From: Medical Director & Revenue Cycle

Subject: E/M Downcoding Policies – Aetna, Humana and Cigna (Effective October 2025)

Bottom Line

Providers should pay extra attention to their documentation so HCI can effectively appeal the automatic downcoding of 99214s and 99215s announced by some commercial payors. This will result in lower initial payments while HCI fights for the payment gap between the code billed versus the code paid. This payment gap will be approximately \$25-50 per encounter affected – the difference between a 99215 and 99214 or 99214 and 99213.

Context

Aetna, Humana, and Cigna have recently implemented automatic downcoding policies for high-level Evaluation and Management (E/M) services, specifically CPT codes 99214 and 99215. These policies involve algorithmic or vendor-based reviews that may result in lower-level code assignment without a full review of medical records. **At this time, it appears UHC is downcoding 100% of applicable claims, while Humana and Cigna remain inconsistent.**

The program evaluates the appropriateness of levels 4 and 5 E&M codes to assess if the level of service billed correlates to the intensity of the service and the severity of the illness.

Reimbursement Policy

- **Aetna and Cigna:** Using algorithms or claims data alone to automatically downgrade the codes physicians assign to cases without reviewing individual patients' medical records. The result is that claims for complex visits will be paid at a lower level. Physicians who disagree with this automatic downcoding will have to appeal. This "deny first, pay later" system presumes physicians are guilty of "upcoding" until proven innocent.
 - **Humana:** Adopted similar strategies using predictive analytics to flag high-intensity coding patterns. Humana's 2025 expansion includes automatic claim review for commercial and Medicare Advantage plans.
 - **UHC:** Maintains documentation-based adjudication; claims not supported by documentation may be adjusted or denied, but did not find public confirmation of a new October 2025 sweeping downcode policy
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Impact on Providers

- Providers may experience reduced reimbursement when high-level E/M services are automatically downcoded by payers. Level 4 (99204/99214) and Level 5 (99205/99215) visits are especially affected, often being reduced one level automatically. This occurs without a request for supporting records, based on diagnosis and claim pattern analysis.
 - The financial impact can be substantial for practices with a high proportion of complex cases, such as pain management, neurology, and internal medicine. Administrative workload also increases as billing and coding teams must review denials and submit appeals for C0150 adjustment.
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Operational Burden

- Increased appeals, chart reviews, and administrative workload.
 - Potential delays in cash flow if appeals are pending.
 - Need to allocate resources (staff hours) to monitor, audit, and correct downcoding cases.
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Compliance & Audit Risk

- Payers may demand medical records or peer reviews for downward-adjusted claims.
 - Repeated or high denial rates could flag external audits by payers or regulators.
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Documentation Best Practices.

National guidelines for coding and documenting E&M services. Both CMS and the American Medical Association have requirements for new and established patient office visits and consultations.

- The medical record should clearly reflect the chief complaint.
 - Review of systems, and past, family, and/or social history can be subject to updates.
 - Generally, decision making with respect to a diagnosed problem is easier than for an identified, undiagnosed problem.
 - Problems that are improving or resolving are usually less complex than those that are worsening or failing to change as expected.
 - The number and type of diagnostic tests used may indicate the number of possible diagnoses.
 - The nature of the medical event may affect the assessment of the level of risk.
 - Office and other outpatient services (99202-99215) include a medically appropriate history and physical examination, when performed.
 - Use best clinical judgment
 - Nature and extent of history and exam will not impact the level of service
 - Appropriate level of service is based on one of the following:
 - Medical decision making
 - Number and complexity of problems addressed at the encounter
 - Amount and/or complexity of data to be reviewed and analyzed
 - Risk of complications and/or morbidity or mortality of patient management decisions made during the visit
 - Total time (counseling and coordination of care). Defined as total time spent on a patient's care on the date of encounter. Includes both face to face service and non-face to face services
 - Only distinct time is summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, count only the time of one individual)
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Recommended Action Steps

- Educate providers and billing staff about payer-specific downcoding policies and C0150 denials.
- Distribute quick reference pocket guides summarizing MDM vs time criteria.
- Monitor trends in E/M downcoding through regular denial analysis.



- Introduce pre-bill E/M audit for all 99204/99205 / 99214/99215 claims: coder or physician reviews before claim submission.
- Create standardized appeal templates including annotated medical records.
- Engage payer representatives to clarify coding expectations and advocate for fair reimbursement.
- Conduct quarterly internal E/M coding audits to ensure compliance and detect early payer trends.
- Monthly review by Revenue Cycle leadership of downcoding metrics and appeal performance.
- Quarterly compliance audits to validate that appeal documentation and rationale are consistent with payer criteria.

Contacts

For assistance with payer denials, appeals, or E/M documentation review:

Email: clientsupport@hcintellect.com

Official Resource

[Aetna and Cigna Announce Automatic Downcoding Policies](#)

[Cigna Evaluation and Management Coding and Accuracy Policy](#)

[Aetna Evaluation and Management Program Claim and Code Review](#)

[UnitedHealthcare Evaluation and Management Policy](#)

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