



Medical Coding and Reimbursement Solutions LLC

Documentation Drives Medical Necessity

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Responding to Downcoded Office Visits

Documentation and appeal strategies for physician practices

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A lower payment deserves a closer look. When a payer reduces an E/M service, review the reason, compare the payment with your contract, and assess whether the record supports the submitted level. Strong documentation makes your clinical reasoning easier to defend, but it cannot prevent every automated adjustment.

What downcoding means

Downcoding occurs when a payer processes a claim at a lower service level or payment level than submitted, such as paying an office visit reported as 99214 at the 99213 level. The AMA describes automated programs that may make these adjustments without first requesting clinical records. Automation does not, by itself, establish that a payer uses AI. [1]

Payer methods and review requirements vary by plan and policy. For example, UnitedHealthcare publishes a Commercial and Individual Exchange E/M policy describing circumstances in which it may request medical records. Confirm the policy that applies to the actual claim. [5]

Document the work that supports the level

For office and other outpatient visits eligible for level selection by MDM or time, make the basis for your code clear. Medical necessity remains central; a longer note does not justify a higher level. [2]

- **Problems addressed:** Describe the condition's status, clinical findings, and how you evaluated or managed it.
- **Data:** Identify relevant tests, records, interpretations, and professional discussions, applying the applicable counting rules.
- **Management risk:** Explain treatment decisions, monitoring, and risks considered. When using MDM, at least two of its three elements must meet the selected level. [3]
- **Time:** If selecting by time, document qualifying physician or APP time on the encounter date. Exclude staff time and separately reported services; apply the requirements for the visit family. [2,3]

Make diagnosis reporting accurate

Report documented conditions that coexist and require or affect care, treatment, or management. Explain how relevant comorbidities influenced your decisions. Use supported specificity and link diagnoses to the services they support; do not copy the entire problem list. An unspecified code can be appropriate when the information needed for greater specificity is unavailable. [4]

A diagnosis label or the number of diagnoses alone does not establish the E/M level. Adding codes simply to make an encounter appear more complex is not appropriate. [3,4]

Recognize and respond to payment changes

- Detect the difference. Compare submitted codes, paid codes when shown, actual payment, and the expected contracted amount. A reduction may occur without changing the displayed CPT code. [1]
- Check the explanation. Review remittance remarks and obtain the payer's stated reason and applicable policy. Distinguish a coding adjustment from a coverage denial or another payment reduction.
- Review the record. Assess the original code against the documented MDM or qualifying time. Correct a genuine coding error; do not alter the record to manufacture support.
- Build a focused appeal when supported. Follow the payer's process and deadline. Identify the disputed service, explain the coding basis, and include the relevant record and remittance through the approved secure channel. [1]
- Track the outcome. Assign an owner and record the payer, plan, submitted level, adjustment, dollars at issue, deadline, decision, and recurring education need.

An example of clearer documentation

Instead of only listing diabetes and hypertension, describe their status and management when actually addressed. For example:

"Diabetes and hypertension remain stable at individualized goals. Reviewed home readings and medication tolerance; continue current prescription regimens. Discussed monitoring and follow-up."

This illustrative note fragment makes the management more visible. Two stable chronic illnesses plus documented prescription drug management may support moderate MDM, but the complete encounter must meet the criteria. A medication list alone is not prescription drug management. [3]

Know your payer and escalation options

Persistent patterns warrant review with your payer representative and specialty or state medical society. AMA advocacy supports greater downcoding transparency. Applicable protections and dispute routes vary; check the plan, contract, and jurisdiction rather than assuming one rule applies to every commercial or Medicare Advantage claim. [6]

How MCRS can help

Repeated E/M reductions? MCRS can review the documentation and coding concerns, identify education needs, and help you prepare a clearer response within an agreed scope. Contact donnine@mcrsconsulting.com to discuss your next step. Keep patient information out of your initial email.

References

1. [AMA. Payer E/M downcoding programs and sample appeal letter.](#)
2. [CMS. Evaluation and Management Services. MLN006764, May 2026.](#)
3. [AMA. E/M code and guideline changes, effective 2023. Confirm current CPT guidance.](#)
4. [CMS and NCHS. FY 2027 ICD-10-CM Official Guidelines, Sections I.B.18 and IV.](#)
5. [UnitedHealthcare. E/M Policy, Professional. Commercial and Individual Exchange. 2026R5007A.](#)
6. [AMA. State Advocacy Update. June 18, 2026.](#)

Sources accessed October 20, 2026. CPT is a registered trademark of the American Medical Association.