The Down-Coding of a Claim

By Franklin J. **Rooks** Jr., PT, MBA, JD

Many medical providers are familiar with the concept of "up-coding." Up-coding is a term used to describe billing for a procedure with a higher reimbursement than the procedure actually performed. A common example is performing a level II office visit (CPT 99213) and billing for a level V (CPT 99215). The converse of "up-coding" is "down-coding". This term describes paying for a lesser valued procedure than the one claimed by the provider. Whereas up-coding may be performed by a provider, the down-coding is done by an insurer. One difference between the two is the legality of the process.

Up-coding is rooted in fraud, and is the basis for many civil actions under the False Claims Act[1]. Down-coding, on the other hand, is a cost-containment mechanism geared towards aligning the claimed procedure with the most accurate CPT description. Down-coding does not imply that the provider up-coded the billed charges. Rather, down-coding indicates that the insurer believes there is a more accurate code. Down-coding is frequently used when a provider bills an unlisted code that is not described by the CPT coding convention. The CPT manual provides for 97039 (unlisted modality), 97139 (unlisted therapeutic procedure), and 97799 (unlisted physical medicine/rehabilitation service or procedure). Down-coding was the subject of a recent Commonwealth Court of Pennsylvania decision regarding a Worker's Compensation determination. The ruling provides some additional clarifications for medical providers who have their procedures down-coded.

THE DOWN-CODING RULE

Under the Pennsylvania Worker's Compensation Medical Cost Containment Code, an insurer may make changes to the CPT codes billed by a provider, upon the satisfaction of several conditions[2]. The insurer must notify the provider in writing of proposed changes to the provider's bill and provide reasons which support the down-coding.[3] In addition, the insurer must have sufficient information to justify the changes, which must be consistent with Medicare guidelines and the PA Worker's Compensation Code.[4] Lastly, the insurer must also give the provider an opportunity to discuss the changes and provide support for the original coding decision.[5] The insurer must have written evidence of the date that notice was sent to the provider.[6] The provider is afforded an opportunity to respond to the insurer's proposed code changes.[7]

The down-coding statute proscribes the time periods in which the insurer or provider must act. The statute gives an insurer 30 days after the receipt of the provider's claims to propose a down-code.[8] After the insurer notifies the provider of the proposed down-coding, the statute gives the provider has 10 days to respond.[9] If the provider fails to respond to the insurer's notice of proposed changes, the provider's right to appeal the down-code is waived.[10] But, when an insurer does not propose a down-code of the provider's claims within 30 days, is the result the same? Does the insurer waive their right to down-code? Two physicians recently confronted this issue.

THE COURT CASE

Two physicians performed vertebral axial decompression procedures on their patients. This procedure, commonly referred to a "Vax-D" was billed as an unlisted procedure using CPT 97799. The worker's compensation insurer down-coded the procedure to 97112 – mechanical traction. The mechanical traction code resulted in a lower reimbursement. However, the insurance company did not notify the physicians of their proposed down-coding until after the 30 day period proscribed by the statute expired. Because the insurer did not follow the time delineated in the statute, the physicians argued that the insurer must pay the full bill. In effect, the physicians claimed that the insurer waived their right to down-code the services because they failed to act within the 30 day period specified by the statute.

The physicians lost their argument. The court held that the insurer does not lose the right to down-code in the event that the insurer fails to initiate the down-coding procedure within 30 days. Instead, the court stated that the statutory interest penalty serves as the remedy for the insurer's failure to act within 30 days. Because the insurer followed the notification and justification procedures specified in the statute, the insurer was permitted to down-code the provider's charges. The insurance company did not waive their right to down-code based on their delay.[11]

THE REMEDIES

The insurer, unlike the provider, does not waive any rights when failing to act in the time proscribed by the statute. The insurance carrier's inaction or delayed action results in a delayed payment. The Worker's Compensation Code requires that an insurer pays all claims within 30 days, unless there is a dispute pertaining to the reasonableness or medical necessity of the procedure.[12] When an insurer proposes changes to the provider's billed codes, the 30 day period in which the insurer is required to make payment is not lengthened.[13] Similarly, if an insurer requests additional information or records from a provider, the request does not lengthen the 30-day period in which payment shall be made to the provider.[14] The provider's remedy for the insurance carrier's delay in down-coding is a statutorily-defined 10% annualized interest.[15]

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1. For an example, see United States v. Comite, 2006 WL 3791340 (E.D. Pa.) 2. See 34 Pa. Code § 127.207(a) 3. Id. 4. Id. 5. Id. 6. See 34 Pa. Code § 127.207(b). 7. Id. 8. See 34 Pa. Code § 127.208(d). 9. See 34 Pa. Code § 127.207(b) 10. See Allen v. Bureau of Workers Compensation Fee Review Hearing Office , 852 A.2d 415 (Pa. Cmwlth. Ct 2004), (discussing that a physician who did not respond within 10 days to insurer's notification of proposed downcoding could not object on appeal to Bureau of Workers' Compensation.) 11. See Yablon v. Bureau of Workers Compensation Fee Review Hearing Office, 2011 WL 1499357 (Pa. Cmwlth Ct.). 12. See 77 P.S. § 531(5). "All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment. . ." Id. 13. See 34 Pa. Code § 127.208(d). 14. See 34 Pa. Code § 127.208(c) 15. See 77 P.S. § 717.1(a)