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September 30, 2025

Councilmember Christina Henderson
Chair, Committee on Health
1350 Pennsylvania Ave NW
Washington, DC 20004

Dear Chair Henderson,

I am testifying on behalf of the Medical Society of the District of Columbia (MSDC), the voice of more than 11,000 licensed physicians caring for patients across the District. Every day, our physicians see how Medicaid makes the difference between patients receiving timely, life-saving care and patients falling through the cracks. The strength of DC's Medicaid program is not an abstract policy matter, it is a matter of health, dignity, and lives.

A strong, viable Medicaid program with a diverse provider network is essential to a Healthy DC. Yet today, this safety net is under threat. MSDC stands shoulder to shoulder with the healthcare community in defending Medicaid and ensuring it continues to work for patients.

As cost pressures mount from the federal government, managed care organizations (MCOs) must not respond by making care harder to access. One troubling practice we are watching closely is *downcoding*. Recently, Cigna announced it would automatically downcode Evaluation and Management (E/M) claims without first reviewing medical records. This means that complex patient visits could be incorrectly reimbursed as simple ones.

Downcoding is not just a billing tactic; it is a barrier to care. It forces physicians to spend hours appealing denials instead of seeing patients. It destabilizes independent practices that already operate on thin margins. And most importantly, it harms patients who risk losing access to thorough, comprehensive visits.

Consider the patient with diabetes, hypertension, and depression who needs a longer, more complex visit. If that visit is automatically downgraded to a "simple" level, the physician is penalized for providing careful, high-quality care. Over time, this erodes access in entire neighborhoods.

While DC MCOs have not publicly announced mandatory downcoding, we know this practice is spreading nationally, both formally and informally, and we are hearing troubling stories from local physicians of local downcoding. MSDC is therefore working to introduce

legislation that will prevent downcoding without appropriate review. Our goal is simple: protect patients and preserve the integrity of care in the District.

Attached to my testimony is an AMA guide to downcoding that explains this issue in greater detail. But the bottom line is this: Medicaid should be a lifeline for patients, not a loophole for profit.

The physicians of the District are committed to caring for every patient who walks through our doors. We ask for your partnership to ensure Medicaid remains strong, accessible, and centered on patients, not paperwork.

Thank you for the opportunity to testify. I welcome your questions.

Sincerely,
Dock G. Winston, MD, MPH, MBA
President, Medical Society of DC

AMA Model Legislation: Transparency in Downcoding Model Act

Physicians regularly report issues with health insurers downcoding claims without notice or clear justification, and with the use of automated tools. Downcoding reduces payment to physicians, threatens practice sustainability, and can disproportionately impact physicians caring for patients with complex needs.

Recognizing that legislative action is needed, the AMA has developed a model bill to assist in state efforts to curb the use of automatic downcoding tools by health insurers and increase transparency and clinical justification when downcoding is used.

This Transparency in Downcoding Model Act takes steps to regulate the practice of downcoding, which often results in reductions in physician payment. Specifically, the bill:

- Prohibits automatic downcoding of claims without a documented review of clinical documentation;
- Prohibits downcoding based solely on diagnosis codes, requiring that any reduction in service level be based on actual clinical review;
- Requires the use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) to notify physicians when a claim has been downcoded and explain the reason for the change;
- Mandates that payers disclose a clear process for appealing downcoded claims;
- Permits physicians to batch similarly downcoded claims for appeal;
- Prohibits discriminatory downcoding practices targeting physicians who routinely treat complex patients or patients with chronic conditions; and
- Establishes enforcement mechanisms and penalties for noncompliance, including administrative fines and claim reprocessing orders.

For more information on this model bill or related efforts, please contact Emily Carroll, Senior Attorney, Advocacy Resource Center at emily.carroll@ama-assn.org.

IN THE GENERAL ASSEMBLY STATE OF _____

Be it enacted by the People of the State of _____, represented in the General Assembly.

Section 1. Title. This act shall be known as and may be cited as the Transparency in Downcoding Act.

Section 2. Purpose. The Legislature hereby finds and declares that:

(a) Downcoding of medical claims, when done without clear justification or transparency, undermines fair payment of healthcare providers and threatens the stability of physician practices;

(b) Improper downcoding may result in harm to patients by disincentivizing care for individuals with complex medical conditions;

(c) It is in the public interest to ensure that all coding adjustments are clinically supported, transparent, appealable, and free from discriminatory targeting.

Section 3. Definitions.

(a) "CARC" refers to Claim Adjustment Reason Codes, which provide the reason for a financial adjustment specific to particular claim or service referenced in the transmitted Accredited Standards Committee (ASC) X12 835 standard transaction adopted by the Department of Health and Human Services under 45 CFR 162.1602.

(b) "Downcoding" means the unilateral alteration by a health insurer of the level of evaluation and management service code or other service code submitted on a claim, resulting in a lower payment.[1]

(c) "Health insurer" means an entity, including an insurance company authorized to issue health insurance, a Health Maintenance Organization (HMO), or any other entity providing a plan of health insurance, health benefits or health care services, and contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. For purposes of this Act, "health insurer" includes a third-party administrator or other payer responsible for adjudicating claims.

(d) "RARC" refers to Remittance Advice Remark Codes, which provide supplemental information about a financial adjustment indicated by a CARC or information about remittance processing.

Section 4. Prohibition of Automatic Downcoding

(a) A health insurer shall not use an automated process, system, or tool to downcode a claim. An automated tool includes, but is not limited to, for the purposes of this section, the use of artificial intelligence.

(b) Downcoding decisions shall be made by a physician licensed in the state of [insert state] and of the same specialty as the treating physician, who shall perform a documented review of the clinical information supporting the billed service.[2]

[1] DRAFTING NOTE: Legislators may consider defining an "adverse determination" in related statutes as "a determination by a payer that results in the denial, reduction, or adjustment of reimbursement, including downcoding, whether full or partial, of a claim" for purposes of establishing more protections for physicians and patients when a claim is downcoded.

[2] DRAFTING NOTE: Some health plans may prohibit physicians from submitting additional clinical information to support the billed services as it becomes available without triggering the appeals process. If such practices are occurring within the state, legislators may wish to clarify that health plans must review any submitted supporting clinical documentation without requiring that the claim be advanced to the appeals process.

Section 5. Prohibition on Diagnosis-Based Downcoding

A health insurer shall not downcode a claim based solely on the reported diagnosis code(s).

Section 6. Notification Requirements for Downcoded Claims

When a claim is downcoded, the health insurer shall notify the physician using the appropriate CARC and RARC to clearly indicate that the claim has been downcoded and provide:

(a) The specific reason for the downcoding, including reference to the clinical criteria used to justify the downcoding;

(b) The original and revised service codes and payment amounts;

(c) The National Provider Identifier of the physician who is responsible for the downcoding decision, as well as the physician's credentials, board certifications, and areas of specialty expertise and training; and

(d) A notice of the right to appeal as described in Section 7. [3]

Section 7. Appeal Process for Downcoded Claims

(a) Health insurers shall provide physicians with a clear and accessible process for appealing downcoded claims, including a written or electronic notice detailing how to initiate an appeal, contact information for the individual managing the appeal, reasonable timelines for submission of an appeal that are no less than [180] days, and timelines for adjudication of the appeal consistent with applicable state law or regulations governing utilization review.[4]

(b) Physicians shall have the right to appeal in batches of similar claims involving substantially similar downcoding issues, without restriction.

[3] DRAFTING NOTE: Legislators can clarify that the appeals process used to appeal pre-claim, concurrent, and post-claim denials is applicable to appealing downcoded claims.

[4] AMA policy requires that a decision on appeal be communicated to physician and patients within 24 hours for urgent care and within 10 calendar days for non-urgent care.

Section 8. **Protections for Patients with Chronic Conditions**

(a) Health insurers shall not use downcoding practices in a targeted or discriminatory manner against physicians who routinely treat patients with complex or chronic conditions.

(b) Any pattern or practice of discriminatory downcoding identified by the Insurance Commissioner or other regulatory authority shall be subject to enforcement actions, including fines, restitution, or suspension of health insurer licensure in this state.

Section 9. Enforcement and Penalties

Violations of this Act shall be enforceable by the Department of Insurance and may include, but not be limited to:

(a) Monetary penalties of up to $50,000 per violation; and

(b) Orders to reprocess improperly downcoded claims with interest.

Section 10. Effective.

This Act shall become effective immediately upon being enacted into law.

Section 11. Severability.

If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.