



WHITEPAPER 1 OF 3 · THE DOWNCODING SERIES

Downcoding

The Silent Revenue Leak

How payer algorithms are quietly repricing orthopaedic office visits, and what it is costing practices

A payment that looks normal

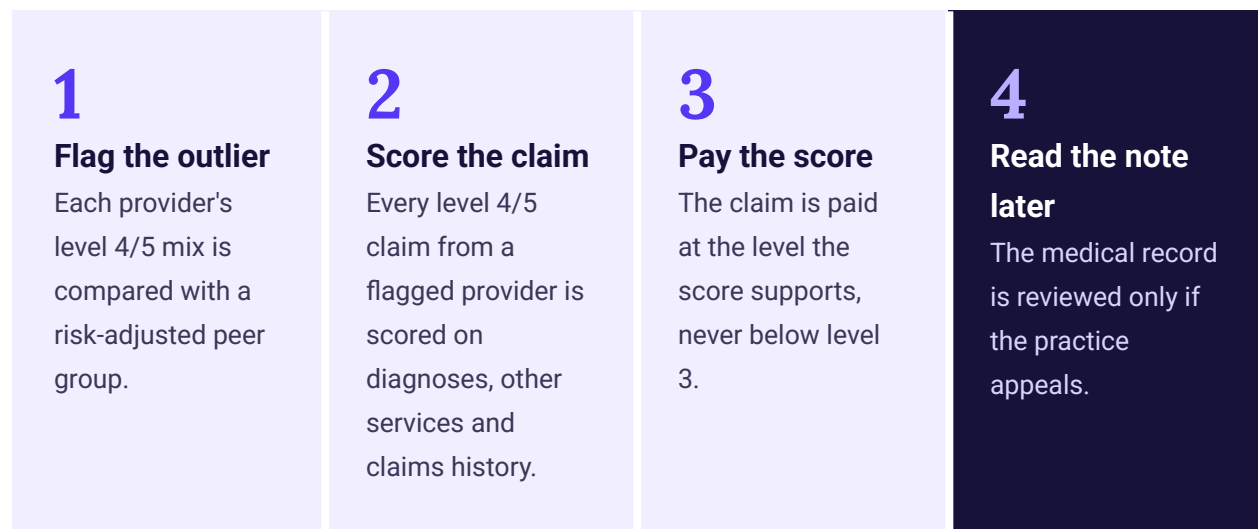
The claim goes out as a 99214. About two weeks later it comes back paid: on time, at a real contract rate, with no denial and no request for records. It has simply been paid as a 99213.

Nothing about that remittance asks for attention, which is why most practices never notice it. At one orthopaedic group Maia analyzed, it happened more than 9,000 times in 18 months.



How the algorithm decides

The BCBS E/M Overcoding policy behind these cuts took effect in March 2025. Its design is typical of the programs now spreading across commercial payers: it decides which providers to watch, then reprices their claims from claim data alone.

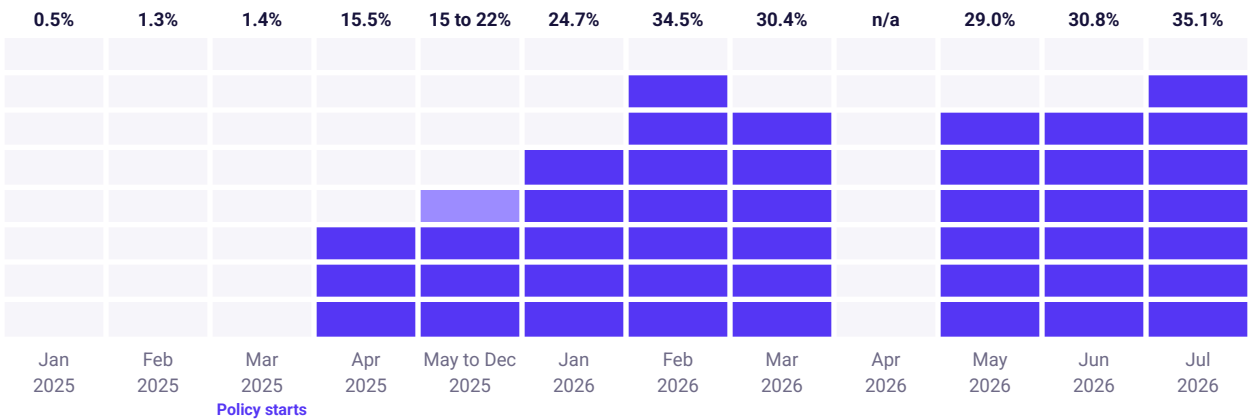


Source: BCBS, Evaluation and Management Overcoding policy (effective March 2025).

It started the month the policy did

Before the policy, almost none of the group's Blue level 4/5 visits were paid at the level-3 rate. The month after it took effect, about one in six were. By mid-2026 it was about one in three.

Share of BCBS level 4/5 office visits paid at the level-3 amount, by month of service



Each square is 5 percentage points, rounded to the nearest square; exact values shown above each column. The lighter square shows the May to December 2025 range. April 2026 is excluded because it was only partly paid at the time of analysis. Source: practice reimbursement reports.

It follows providers, not visits

The cuts were not spread evenly. Half of the group's providers had 27% to 56% of their Blue level 4/5 visits paid at level 3. The other half had essentially none.

Providers affected



- **Volume alone does not predict it.** Flagged providers billed level 4/5 more often (a median of 71% of visits vs 47%), but some providers billing 80% to 90% level 4/5 were untouched, while some near 50% were flagged.
- **It is not a specialty issue.** Flagged providers included general orthopaedics, hand and foot, and sports medicine surgeons, as well as PAs and NPs.
- **It happens before anyone reads the note.** Cut claims were paid at the level-3 rate to the cent, in a median of 14 days versus 13 for untouched claims. No records were requested.
- **It reaches every Blue plan.** Members of other Blue plans, whose claims are processed through BlueCard, showed the same pattern.

And it is not just one payer

BCBS accounted for most of the losses, but the same providers saw smaller cuts from Humana, Cigna and Aetna. Medicare and UnitedHealthcare showed none.

Payer	Claims cut	Estimated lost revenue
BCBS	7,552	\$259,310
Humana	708	\$24,924
Other Blue plans	about 400	about \$18,000
Cigna	325	\$11,443
Aetna	156	\$6,913
Total	9,000+	\$320,000+

Estimated from visits after the BCBS policy took effect. Lost revenue is the payer's median full payment for the billed code minus the amount paid.

Several payers have published programs with the same basic design. **Cigna** (policy R49, effective October 1, 2025) adjusts 99204 to 99205, 99214 to 99215 and 99244 to 99245 when claim data does not support the level. **Aetna** runs an E&M claim and code review on select providers, according to physician society reporting. Another Blue plan announced a similar program in October 2025.

Regulators have started to respond. Some state regulators have pushed payers to stop or pause automatic downcoding, and some state legislatures have passed laws requiring notice of downcoding and limiting downcoding by artificial intelligence alone. The American Academy of Orthopaedic Surgeons is supporting state legislation. Until those efforts spread, practices should expect these programs to stay.

Why the cuts stick

The algorithm reads the claim. Whether the cut holds up depends on the note.

When Maia reviewed 178 recent level 4/5 visits exposed to the program, 119 of them (67%) had notes that supported only a lower level under the AMA medical decision making table. The most common gap was not note length. It was a missing record of the decision the provider made: the prescription changed, or the injection or surgery decided with its risks weighed.

That is good news. It means much of the problem is within the practice's control. Whitepaper 2 shows where the notes fall short and how to fix them.

Is this happening to your practice?

SIX SIGNS TO LOOK FOR

Because these cuts look like ordinary payments, they rarely surface on their own. Look in your remittances for:

- Level 4/5 visits paid at exactly your level-3 contract rate
- A step up in those payments after a payer's policy date (April 2025 at BCBS, October 2025 at Cigna)
- Cuts concentrated on some providers while others are untouched
- Cut claims paid on a normal timeline, with no records request
- The same pattern on members of other Blue plans
- A smaller version of it at Humana, Cigna or Aetna

It also helps to ask each commercial payer for any outlier notices sent to the practice, and for the peer comparison and look-back period used to flag providers.

The series

Finding the cuts is the first step. The next two papers cover how to stop them and how to recover what is recoverable.

WHITEPAPER 1 · YOU ARE HERE The Silent Downcode

What automated E/M repricing is costing orthopaedic practices, and how to spot it.

WHITEPAPER 2 Document the Decision

Where notes fall short of level 4, and the few sentences that fix it.

WHITEPAPER 3 Appeal What the Note Supports

Why blanket appeals lose money, and how automation makes targeted appeals pay.

WORK WITH MAIA

Maia can run this analysis on your own reimbursement data: which providers are flagged, by which payers, what it is costing you, and what your notes are missing.

Contact Eric Lau, Co-founder and CRO, or book a demo at usemaia.com.

Methodology and sources

- Case study: one US orthopaedic group's reimbursement reports, office E/M lines only. All figures are aggregates. The practice and its providers are not named, and no patient data was used.
- "Paid at level 3": a billed 99214, 99215, 99204 or 99205 paid within 1% of that payer's most common level-3 payment, for the same provider type and quarter.
- Lost revenue is an estimate, not a remittance figure. April 2026 and August to September 2026 were partly paid and are left out of the trend.
- The reports carry no adjustment reason codes. The link to the BCBS program rests on the policy text and the matching pattern. BlueCard processing and the other payers' programs are inferred from the data, not confirmed.
- Maia results: the current Maia build, run retrospectively on recent visits. Maia was not in use at this practice when these claims were billed.
- Payer program details for Cigna and Aetna come from physician society reporting; confirm current terms with each payer.

SOURCES

- [AAFP: Cigna's downcoding policy gets pushback from physician groups](#)
- [AAO-HNS: Comment letter to Aetna on E&M downcoding \(September 2025\)](#)
- [AAOS: Downcoding Action Guide \(July 2026\)](#)