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Coalition of State Rheumatology Organizations

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September 22, 2025

Cigna – Corporate Headquarters
The Cigna Group
900 Cottage Grove Road
Bloomfield, CT 06002

Subject: Formal Notice of Non-Compliance with Federal Law – Downcoding of E/M Services

Dear David Cordani,

On behalf of the **Coalition of State Rheumatology Organizations (CSRO)**, we are writing to formally demand that your organization immediately cease the unlawful practice of **downcoding Evaluation and Management (E/M) services**, particularly the routine and unsubstantiated reduction of **CPT code 99214 to 99213**, or other similar E/M downgrades. The American Medical Association has given references for the following violations.

This practice is not only improper but directly violates multiple federal laws and regulations, particularly those established under **HIPAA**, the **Affordable Care Act**, and potentially the **United States Criminal Code**.

1. Violation of HIPAA Standard Code Set Requirements

Under **45 C.F.R. § 162.1002**, HIPAA mandates the use of **standard medical code sets**, including:

Current Procedural Terminology (CPT®), maintained by the American Medical Association (AMA), for outpatient procedures and services.

Per HIPAA, **health insurers are required to accept and adjudicate CPT codes based on their official definitions**. It is **unlawful for payers to reinterpret or modify the definitions of CPT codes** to suit internal payment algorithms or cost-containment strategies. The AMA's CPT 2024 guidelines specifically state that **E/M code selection is based on either Medical Decision Making (MDM) or total time spent**, not the diagnosis code or payer preferences.

Reference: 45 C.F.R. § 162.1002(b); HHS, "Adoption of Standards for Health Care Electronic Transactions"

2. Unauthorized Alteration of Electronic Health Care Transactions

Under **45 C.F.R. §§ 162.1601–162.1602**, HIPAA establishes mandatory transaction standards, including:

- The **837 Professional (837P)** transaction set for claim submission.
- The **835 Electronic Remittance Advice (ERA)** for payment information.

Your organization's routine downcoding of claims submitted with CPT 99214—then reflecting the altered 99213 in the 835 ERA without notifying providers that the original code was changed—is a **clear violation of HIPAA transaction integrity requirements**. The 835 must reflect the claim **as submitted**, with appropriate **adjudication status** and **claim adjustment reason codes (CARCs)**.

Reference: 45 C.F.R. § 162.1601; ASC X12N Implementation Guides

3. Misuse of ICD-10 Codes in Determining E/M Levels

The **ICD-10-CM** code set, adopted under HIPAA, is intended solely for **reporting diagnoses**, not for determining service levels or payment.

Several payer systems are improperly using ICD-10 codes as a proxy for “appropriate” E/M levels, i.e., denying 99214 when associated with "non-complex" ICD-10 codes. This is **medically and legally invalid**.

E/M services must be based on the nature of the **history, exam, and medical decision-making**, or **total time spent**, not diagnosis codes. This misuse is inconsistent with both **CMS** and **AMA** guidance.

Reference: AMA CPT E/M Guidelines; ICD-10-CM Official Guidelines for Coding and Reporting; CMS MLN Matters SE21001

4. Potential Criminal Liability Under Wire Fraud Statutes (18 U.S.C. § 1343)

The **systematic alteration of claim data**—submitted by licensed providers under national standards—and its **transmission across state lines via electronic means**, for the purpose of **financial gain**, falls under the federal definition of **wire fraud**:

"Whoever, having devised... any scheme or artifice to defraud... transmits... by means of wire, radio, or television communication in interstate or foreign commerce, any writings... for the purpose of executing such scheme... shall be fined or imprisoned..."

If this practice is applied to **Medicare Advantage** or **federal exchange plans**, it may also constitute **False Claims Act** violations (31 U.S.C. §§ 3729–3733).

Reference: 18 U.S.C. § 1343 – Wire Fraud; 31 U.S.C. § 3729 – False Claims Act

5. Violation of Due Process and Provider Contract Terms

Providers have reported that your downcoding practices often occur:

- Without **notification** of code changes in real time;
- Without **clinical justification** or review by a licensed medical professional;

- Without access to **appeal or peer-to-peer review**.

Such actions violate both **contractual due process rights** and fair claims adjudication practices under both **state insurance codes** and **federal healthcare standards**.

In light of these findings, it is clear that you must:

1. **Cease all automated or algorithmic downcoding of E/M services** without individual review by a licensed clinician;
2. **Provide full transparency** regarding any payment integrity program affecting E/M codes;
3. **Establish a provider-friendly appeals process** with clearly communicated rationales for each downcoded claim;
4. **Reprocess and reimburse** all improperly downcoded claims retroactively;

Regulatory Notifications Pending

If no response or remediation is received, CSRO will initiate formal complaints with:

- **U.S. Department of Health and Human Services – Office for Civil Rights (OCR)**
- **Centers for Medicare & Medicaid Services (CMS)**
- **U.S. Department of Justice – Healthcare Fraud Unit**
- **State Departments of Insurance**
- **National Association of Insurance Commissioners (NAIC)**

This letter serves as **official notice of non-compliance**, and we strongly urge your leadership and compliance departments to review these practices and respond appropriately.

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