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ALL PLAN LETTER

DATE: October 23, 2026

TO: All Health Care Service Plans

FROM: Jenny Phillips
Deputy Director
Office of Plan Licensing

SUBJECT: APL 26-015 (OPL) - Downcoding Practices and Filing Requirements

This All-Plan Letter (APL) provides guidance regarding the implementation and use of downcoding practices as part of a health care service plan's (plan or plans) claims adjudication and payment processes and antifraud plan. This APL includes filing and compliance requirements for all plans that have implemented or seek to implement downcoding practices.

I. General Overview

Downcoding is not expressly prohibited by the Knox-Keene Act¹ and may be used to address discrepancies between billed codes and the level of service the plan believes is supported by a complete claim. Downcoding may also be a component of the plan's antifraud plan to address claims that are upcoded to a higher compensation level. However, any plans implementing or using downcoding practices must comply with all applicable provisions of the Act.

For purposes of this APL, downcoding includes, but is not limited to, any practice where the plan or its delegate adjudicates and reimburses a claim at a less complex or lower level of service than billed by the provider.

A. Disclosure Requirements

Rule 1300.71(o)(2) requires plans to disclose "detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims" upon a provider's written request, including clearly and accurately stating the policies regarding "payment

¹ California Health and Safety Code sections 1340 et seq. (Act). References herein to "Section" are to sections of the Act. References to "Rule" refer to the California Code of Regulations, title 28.

adjustments due to coding changes.” Such disclosures must be “in sufficient detail and in an understandable format . . . so that a reasonable person with sufficient training, experience and competence in claims processing can determine the payment to be made according to the terms of the contract.”

Downcoding practices are subject to the required disclosure under Rule 1300.71(o)(2), as they constitute part of the plan’s payment policies, rules, and methodologies and are “payment adjustments due to coding changes” used to adjudicate claims. Such disclosure enables providers to verify that claims were adjudicated according to the plan’s stated policies, rules, and methodologies, evaluate the plan’s reimbursement determination, and dispute any improper adjustments. Therefore, plans must disclose the criteria, policies, and methodologies used to identify providers or claims subject to downcoding and to determine the adjusted service level.

B. Complete Claim

Sections 1371 and 1371.35 require plans to reimburse a complete claim, or portion thereof, as soon as practicable but no later than 30 calendar days after receipt of the claim. A “complete claim” includes the claim form and all “attachments and supplemental information or documentation” which provides “reasonably relevant information”² and “information necessary to determine payer liability.”³ Before downcoding a claim, a plan must ensure that it has a complete claim and has requested supplemental information or documentation necessary to determine payor liability if not already submitted by the provider.⁴ Accordingly, plans must review *all* submitted supplemental information or documentation, which may include medical records, before making any determination and downcoding a claim. Prior to downcoding a claim, plans may not limit its review solely to the claim form unless it has requested such supplemental information or documentation from a provider and none has been submitted.

If, after reviewing all submitted supplemental information or documentation, the plan determines that a billed service does not meet the criteria for the level billed, then it must reimburse the provider for the portion of the claim corresponding to the lower level of service determined to be supported by the supplemental information or documentation. A plan may not withhold payment for the entire claim when portions of the claim are supported by the submitted supplemental information or documentation.

When a claim is downcoded to a lower level of service, Rule 1300.71.38(b) requires plans to notify the provider of the availability of the provider dispute resolution mechanism and procedures for submitting a dispute. Plans must permit the provider to submit such a dispute, including additional supporting supplemental information or documentation, to request reconsideration of the adjustment and seek reimbursement

² Rule 1300.71(a)(10)

³ Rule 1300.71(a)(11).

⁴ Nothing in this APL is intended to require plans to request supplemental information or documentation prior to reimbursing approved, unadjusted, or uncontested claims.

at the originally billed level of service where supported by the supplemental information or documentation submitted.

Downcoding practices are considered adjustments subject to Rule 1300.71(d)(1), which prohibits a plan from improperly denying, adjusting, or contesting a claim. For each claim that is either denied, adjusted, or contested, plans must provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in subdivisions (g) and (h). Accordingly, plans must demonstrate that any downcoding practices are consistent with Rule 1300.71(d)(1) and file the relevant rules, policies, and methodologies utilized for such practices. Any undisclosed practices may constitute an improper adjustment of a claim.

II. Compliance and Filing Requirements

Please submit by November 23, 2026, one filing via eFiling as an **Amendment** titled **“APL 26-015 Downcoding Compliance”** with the following exhibits to demonstrate compliance with the statutory and regulatory requirements discussed in this APL.

A. Exhibit E-1: Summary of eFiling Information.

Plans must submit an Exhibit E-1 which provides the following information:

- Explain if the plan or its contracted entities have implemented or engages in any downcoding practices as part of its claims adjudication and payment processes. If so, provide the following information and affirmations:
 - Explain whether any downcoding practice has a material effect on the plan's operations in accordance with Rule 1300.52.4(d), which would require submission of a Notice of Material Modification, and if applicable, the date by which the Notice of Material Modification will be filed.
 - Provide the implementation date of any downcoding practice.
 - Indicate whether the plan contracts with any entities to perform downcoding, including any entities that perform claim functions that involve reviewing, modifying, or adjusting claims which result in an adjustment to the level of service originally billed by a provider.
 - Explain how the plan disclosed to its providers the methodologies, rules, and policies related to its downcoding practices pursuant to Rule 1300.71(o)(2), including the date and method of disclosure.
 - Affirm the plan and its delegates will reimburse a complete claim, or portion of a claim, including any portion resulting from a downcoding adjustment, as soon as practicable, but no later than 30 calendar days after receipt of the claim by the plan.

- Affirm that if a claim or portion thereof, including any portion resulting from a downcoding adjustment, does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, the claimant will be notified, in writing, that the claim or portion thereof is contested or denied, as soon as practicable, but no later than 30 calendar days after receipt of the claim by the plan.
- Affirm that if a claim or portion thereof, including any portion resulting from a downcoding adjustment, is contested on the basis that the plan has not received the supplemental information or documentation which provides reasonably relevant information and information necessary to determine payer liability for the claim or portion thereof, the plan will complete reconsideration of the claim within 30 calendar days after receipt of the additional supplemental information or documentation.
- Affirm the plan will review all attachments and supplemental information or documentation, which may include medical records, that provide reasonably relevant information and information necessary to determine payer liability, prior to downcoding a claim.
- Affirm the plan will not limit its review solely to the claim form when making any determination and downcoding a claim, unless the plan has requested supporting supplemental information or documentation from a provider and none has been submitted.
- Affirm that before downcoding a claim, the plan will ensure that it has a complete claim and request supporting supplemental information or documentation if the provider has not already submitted this information.
- Affirm the plan will not use undisclosed downcoding practices to improperly deny, adjust, or contest claims in violation of Rule 1300.71(d)(1).
- Affirm the plan will disclose to its providers all detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims related to its downcoding practices, pursuant to Rule 1300.71(o)(2).
- Explain how the plan will ensure the member is reimbursed in the event that the member has overpaid their coinsurance or cost-sharing amount on a claim that has been downcoded by the plan.

B. Claims Policies and Procedures

- Submit any policies and procedures that the plan has disclosed to providers, as an Exhibit II-4, outlining the methodologies, rules, and other requirements for identifying providers and claims subject to downcoding and determining the appropriate level of service. This includes, but is not limited to, any policies, rules

and methodologies used to adjudicate claims pursuant to Sections 1371 and 1371.35 and Rule 1300.71.

C. Administrative Services Agreements (ASA)

- Submit any ASAs, as an Exhibit N-1, that delegate claims functions to another entity which involve downcoding, including reviewing, modifying, or adjusting claims resulting in an adjustment to the level of service originally billed by the provider.
- Submit the compensation terms of the ASA as an Exhibit N-6.
- Submit the oversight policies and procedures, as an Exhibit N-2 or N-5. The plan remains responsible for ensuring its delegated entities comply with the requirements of this APL. This responsibility is demonstrated through the plan's oversight policies and procedures, which must describe how the plan monitors the delegated functions for compliance.
- Any new ASA not previously filed with and approved by the Department of Managed Health Care (the Department) would need to be filed as separate material modification filing.

D. Plan-to-Plan Agreements

- Submit any Plan-to-Plan Agreements, as an Exhibit P-5, that delegate claims functions to another plan which involve downcoding, including reviewing, modifying, or adjusting claims resulting in an adjustment to the level of service originally billed by the provider.
- Any new Plan-to-Plan Agreements not previously filed with and approved by the Department would need to be filed as separate material modification filing.

E. Other Documents Required to Be Filed with the Department, Including Anti-Fraud Plans

- Submit any other documents required to be filed with the Department, if they require amendment as a result of the implementation of a downcoding practice.
- Any changes to an antifraud plan (Exhibit J-8) must be filed in accordance with Section 1348(b) and Section 1352.

The Department reminds the plans that the failure to comply with the above filing obligations may result in disciplinary proceedings against the plan pursuant to Section 1386, including but not limited to, administrative penalties.

If the plan is relying on previously approved documents to demonstrate compliance with the above, please provide the applicable filing numbers and the specific documents within Exhibit E-1.

For questions or concerns regarding this APL, please contact the plan's assigned Office of Plan Licensing's reviewer.