TO: Members of the Tennessee House Finance, Ways, and Means Subcommittee

FROM: American Osteopathic Association
Tennessee Osteopathic Medical Association

DATE: April 14, 2026

SUBJECT: SUPPORT for TN House Bill 2619

The American Osteopathic Association (AOA) and the Tennessee Osteopathic Medical Association (TOMA) write today to express our strong support for TN HB 2619. This bill would (1) prohibit insurers from automatically downcoding medical claims; (2) require insurers to involve physicians and provide a clear rationale for downcoded claims; and (3) prevent health plans from discriminating against patients with high-cost medical conditions or a history of significant claims. **The AOA and TOMA believe that these important guardrails will lead to a more transparent claims review process based on clinical documentation, while ensuring that both health insurers and providers work to provide the most cost-effective care to patients.**

As a medical professional association representing more than 207,000 osteopathic physicians (DOs) and osteopathic medical students (OMSs) nationwide, the AOA works to promote evidence-based policies and sound public health practices that advance the overall health and well-being of patients across the country. TOMA, our state affiliate, represents almost 2,400 DOs providing patient care in Tennessee, as well as approximately 1,800 OMSs enrolled in the Baptist Health Sciences University College of Osteopathic Medicine in Memphis and the Lincoln Memorial University-DeBusk College of Osteopathic Medicine locations in Harrogate and Knoxville.

Some insurers have begun implementing automatic downcoding of medical claims (i.e. assigning a lower-level code to a service than what was actually performed, resulting in lower physician payment) based solely on the patient's diagnosis, review by artificial intelligence, etc. This practice poses significant risks to clinical care, administrative efficiency, and fair payment for physicians, especially in primary care, though some specialties are affected as well. DOs are particularly impacted, since 57% provide primary care and frequently deliver complex, whole-person care to their patients. While current requirements mandate that physicians submit claims with additional clinical information to both inform the insurer and justify the expense, insurers are not required to follow a similar procedure when downcoding claims. Instead, inappropriate or undisclosed criteria or algorithms may be used to determine downcoding decisions and deny appropriate payment to physicians. This methodology denies physicians due process while allowing insurers to circumvent prompt payment laws in many states. Without transparency, physicians cannot reasonably anticipate or prevent adjustments to their claims, creating systemic unfairness. Further, the practice of systematically downcoding claims without individualized review may breach contractual "good faith" and "fair dealing" principles under state insurance laws, raising significant red flags and eroding trust in the relationships between providers and payers.

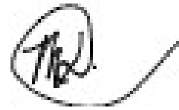
In addition to the aforementioned issues, automatic downcoding increases the administrative burden on physicians and financially harms health care providers as a whole. Automatic downcoding decisions force physician practices to engage in costly appeals for routine claims, delaying payments by an average of 20 – 30 days. For small, independent practices already facing workforce shortages and rising operational

costs, these repeated delays and additional work translate into anywhere from $15,000 - $50,000 per year in preventable losses. These losses jeopardize the financial stability of small clinics in particular, which threatens access to care in underserved areas.

Lastly, but perhaps most importantly, automatic downcoding negatively impacts patient care and exacerbates the crisis of physician burnout. Requiring physicians to work around opaque downcoding policies is likely to push them to lower coding levels. That response compromises clinical accuracy, increases frustration, and accelerates burnout, undermining both provider well-being and patient care outcomes. For DOs, whose approach centers on whole-person care and preventive medicine, these pressures reduce the time and attention available to address the full scope of patient needs. The result is a diminished care experience for patients and increased emotional exhaustion for physicians, both of which contribute to poorer outcomes and higher long-term cost.

The AOA and TOMA urge you to support high-quality, cost-effective care for all patients, by supporting HB 2619. Should you need any additional information, please contact Raine Richards, JD, Vice President of State and International Affairs at rrichards@osteopathic.org.

Sincerely,



Robert G.G. Piccinini, DO, D. FACN
President, AOA

Michael Douglas, DO
President, TOMA

CC: Richard Thacker, DO, President-elect, AOA
Jennifer Hauler, DO, Chair, Department of Governmental Affairs, AOA
J. Michael Wieting, DO, Chair, Council on State Health Affairs, AOA
Kathleen Creason, MBA, Chief Executive Officer, AOA
Raine Richards, JD, Vice President, State and International Affairs, AOA
Uma Loganathan, Associate, State Government Affairs, AOA
Betsy Hilt, Executive Director, TOMA

Resources:

1. American Health Information Management Association (AHIMA). (2022, June 1). *Claims denials: A step-by-step approach to resolution. Journal of AHIMA.* Retrieved from https://journal.ahima.org/page/claims-denials-a-step-by-step-approach-to-resolution

2. Cain, R. A. (2024, September 25). *Applying Daniel Pink's insights to reform U.S. healthcare. American Association of Colleges of Osteopathic Medicine.* https://www.aacom.org/news-reports/news/2024/09/25/applying-daniel-pink-s-insights-to-reform-ushealthcare

3. CPT 2025 Professional. Chicago: American Medical Association. 2024: 9.