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Code shift: A decade of medical coding trends and their financial impacts

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From emergency department visits to inpatient admissions: 10 years of Medicare fee-for-service coding intensity and up to $4.4 billion in additional payments

Introduction

Medical coding intensity has become a growing topic of concern in U.S. healthcare as coding-driven impacts on provider reimbursement continue to rise and AI-assisted clinical documentation integrity (CDI) technologies become increasingly prevalent.[1,2] The Medicare program alone accounted for approximately 62 million beneficiaries aged 65 and older and $1.2 trillion in total expenditures in 2025, so even modest shifts in coding patterns can translate into millions of dollars in aggregate reimbursement impacts that directly affect program costs, risk adjustment, and the sustainability of payment models.[3] Tracking and interpreting changes in coding behavior has become an important part of assessing provider payment levels, understanding the specific impacts of coding technologies, and making decisions about the long-term approach of payment systems.

This paper analyzes nationwide medical coding trends and their associated financial implications using Medicare fee-for-service (FFS) claims data from the Centers for Medicare and Medicaid (CMS) Virtual Research Data Center, focusing on claims incurred from 2017 through March 2026 and paid through June 2026.[4] The scale and consistency of this data make it well suited for longitudinal trend analysis, and while Medicare FFS differs from Medicare Advantage, Medicaid, and commercial markets, the observed coding trends can provide meaningful insight across all lines of business since nearly all acute care hospitals participate in Medicare FFS and most physicians accept Medicare patients.[5]

The implications of coding intensity trends extend across a broad range of stakeholders. All stakeholders have an interest in improving efficiency and reducing administrative burdens so that the system can focus on care delivery. Payers, employers, and plan sponsors rely on accurate coding to establish appropriate reimbursement rates, apply risk adjustment, and manage total cost of care. Providers and health systems have a direct financial interest in coding practices that accurately reflect the complexity of their patient populations to ensure they are being appropriately compensated for their services. Policymakers and regulators depend on reliable coding data to design payment systems and oversee program integrity. Finally, patients are also affected because coding accuracy influences premiums, cost-sharing, and coverage determinations. In this paper, we analyze how coding intensity has evolved over the past decade, which services and settings have shifted the most, and what the financial implications of those shifts are from a Medicare perspective.

1. Contreras, B. (May 16, 2025). Outpatient bills keep rising as ‘upcoding’ becomes the norm. Managed Healthcare Executive. Retrieved September 9, 2026, from https://www.managedhealthcareexecutive.com/view/outpatient-bills-keep-rising-as-upcoding-becomes-the-norm.
2. American Medical Association. (July 9, 2026). AMA policy on AI development, deployment and use. Retrieved September 9, 2026, from https://www.ama-assn.org/practice-management/digital-health/augmented-intelligence-medicine.
3. The Boards of Trustees, Federal Hospital Insurance, and Federal Supplementary Medical Insurance Trust Funds. (June 9, 2026). The 2026 annual report. Retrieved September 9, 2026, from https://www.cms.gov/oact/tr/2026.
4. Centers for Medicare and Medicaid Services. Chronic Conditions Data Warehouse. Retrieved September 9, 2026, from https://www2.ccwdata.org/web/guest/home/.
5. Medicare Payment Advisory Commission (MedPAC). (March 2026). Chapter 4, Physician and other health professional services. Report to the Congress: Medicare payment policy. Washington, DC. Retrieved September 9, 2026, from https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

Defining medical coding, coding intensity, and upcoding

Medical coding is the process of translating physician and facility documentation of medical services into standardized code sets for billing and administration. The major code sets used in the United States include the International Classification of Diseases (ICD) for tracking diagnoses and inpatient procedures, and the Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) for tracking outpatient and professional procedures. The assignment of these codes is a core part of provider billing as payers rely on submitted codes to determine the level of reimbursement for each clinical encounter. In Medicare FFS, submitted codes determine the Medicare Severity Diagnosis-Related Group (MS-DRG) assigned to an inpatient stay or the Ambulatory Payment Classification (APC) for an outpatient service, directly affecting hospital payment amounts.[6] In addition to reimbursement purposes, medical coding underpins a wide array of administrative and analytical functions, including risk adjustment, care management, program oversight, and healthcare cost trend analysis, all of which are sensitive to shifts in coding practices over time.

Coding intensity refers to the level of specificity, completeness, or severity in diagnosis and procedure documentation. Changes over time may reflect improvements in clinical documentation, coding accuracy, or data capture, as well as changes in coding guidelines. These changes may also affect claim weights, risk scores, and reimbursement in payment systems that rely on coded diagnoses and procedure codes. Consider a patient whose chart initially documented *sepsis*, but whose labs and vitals indicate *acute kidney injury (AKI) secondary to the infection*. If a medical coder or CDI technology prompts the physician to confirm and document this more specific diagnosis, the resulting code change to *severe sepsis with AKI* constitutes appropriate coding intensity, since it is fully supported by clinical evidence already present in the record.

However, increases in coding intensity may not always correspond directly with changes in the underlying clinical acuity of the patient population or the resources necessary to deliver care. One driver of this divergence is the improper practice known as **upcoding**, which occurs when a diagnosis or procedure code is assigned at a higher severity, complexity, or reimbursement level than is supported by the associated medical record, clinical evidence, and applicable coding guidelines. For example, an inpatient hospital admission for *pneumonia* may be coded with a secondary *acute respiratory distress syndrome (ARDS)* diagnosis—a major complication or comorbidity (MCC)—that can shift the claim to a higher paying MS-DRG, even if the medical record does not support the clinical and coding criteria for *ARDS*.

With AI-assisted coding tools and other advanced technologies becoming mainstream across the healthcare industry, it has become important to distinguish clinically supported improvements in documentation quality and coding accuracy from changes in coded severity that may reflect coding behavior rather than actual changes in patient acuity or service intensity.[7]

6. CMS.gov. (September 8, 2026). MS-DRG Classifications and Software. Retrieved September 9, 2026, from https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software.

7. Diaz, N. (March 10, 2026). Epic AI adoption surpasses 85% of customers. Becker's Health IT. Retrieved September 9, 2026, from https://www.beckershospitalreview.com/healthcare-information-technology/ehrs/epic-ai-adoption-surpasses-85-of-customers.

Coding intensity in emergency department care and its impact

As one of the highest volume settings in the U.S. healthcare system and a site of wide-ranging clinical complexity, emergency departments (EDs) carry significant reimbursement implications under Medicare and other payment systems, making shifts in coding patterns consequential for aggregate program spending. In 2022, the Medicare program documented approximately 34 million ED visits.[8] In Medicare FFS, hospital outpatient ED visits are billed using CPT codes 99281 through 99285, which correspond to five ascending levels of medical decision-making and resource utilization. Because higher complexity codes map to higher weighted APCs under the Medicare Outpatient Prospective Payment System (OPPS), the distribution of visits across code levels has a direct and material impact on aggregate Medicare expenditures.

Figure 1 details the five ED visit CPT codes and illustrates the reimbursement gradient at each level in 2025.

FIGURE 1: CPT CODES FOR ED VISITS

CPT CODE	SHORT DESCRIPTION[1]	COMPLEXITY LEVEL	APC	APC WEIGHT (2025)[2]	PAYMENT RATE (2025)[3]	PAYMENT DIFFERENTIAL VS. 99281
99281	ED visit; may not require presence of a physician or qualified healthcare professional	Minimal or none	5021	0.9875	$88.05	-
99282	ED visit; medically appropriate history and/or exam with straightforward medical decision-making	Straightforward	5022	1.7759	$158.36	$70.31
99283	ED visit; medically appropriate history and/or exam with low-complexity medical decision-making	Low	5023	3.1052	$276.89	$188.84
99284	ED visit; medically appropriate history and/or exam with moderate-complexity medical decision-making	Moderate	5024	4.7754	$425.82	$337.77
99285	ED visit; medically appropriate history and/or exam with high-complexity medical decision-making	High	5025	6.8757	$613.10	$525.05

1. Short descriptions adapted from: American Medical Association. (2022). CPT evaluation and management (E/M) codes and guideline changes effective January 1, 2023. Retrieved September 9, 2026, from https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf.

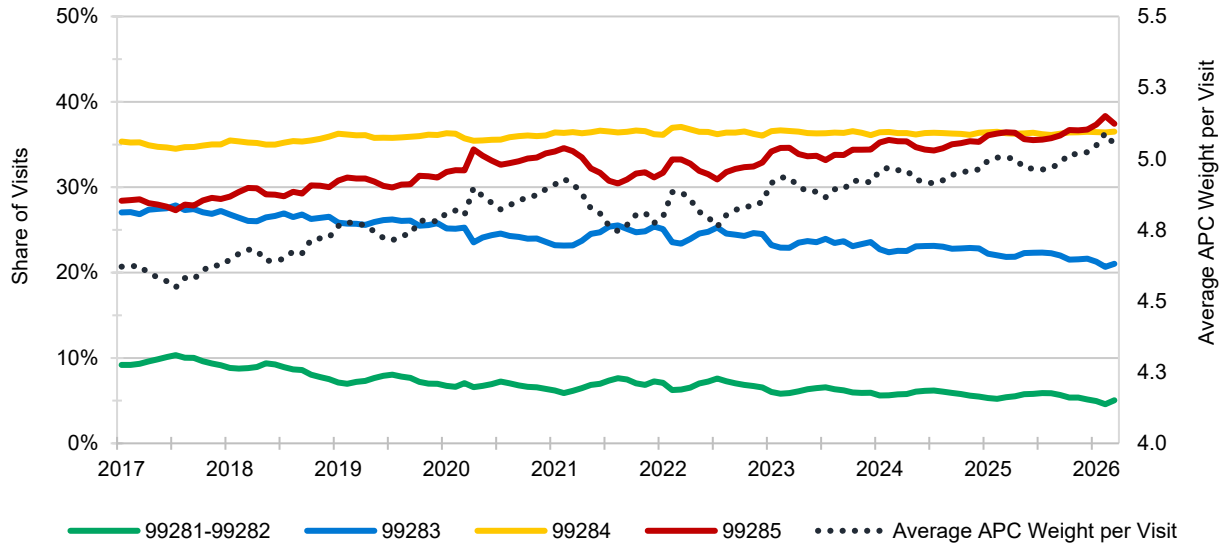
2. CMS.gov. (April 2025.) April 2025 Addendum B. Retrieved September 9, 2026, from https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/quarterly-addenda-updates/april-2025-addendum-b.

The $525.05 payment differential between the lowest and highest complexity ED codes means that differences in documented complexity carry substantial payment consequences. This dynamic makes the ED setting particularly relevant to any examination of coding intensity trends.

Figure 2 shows how that distribution and the corresponding average APC weight per visit have evolved from 2017 through March 2026, revealing an increase in the relative frequency of higher complexity ED codes over the period.

8. Cairns, C. & Kang, K. National hospital ambulatory medical care survey: 2022 emergency department summary tables. U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved September 9, 2026, from https://www.cdc.gov/nchs/data/nhamcs/web_tables/2022-nhamcs-ed-web-tables.pdf.

FIGURE 2: ED VISIT DISTRIBUTION BY CPT CODE AND AVERAGE APC WEIGHT PER VISIT, 2017–2026[1]



1. Medicare FFS claims data source: KFF. (August 4, 2026). Figure 4, "Spending on physician services and other Part B services accounts for the largest share of Medicare benefit spending." The facts about Medicare spending. Retrieved September 9, 2026, from https://www.kff.org/medicare/the-facts-about-medicare-spending/?entry=table-of-contents-spending-on-medicare-benefits-and-medicare-advantage.

The most notable trend is the gradual rise in high-complexity visits (CPT code 99285), which grew from roughly 28% of visits in 2017 to 38% in 2026, making it the most frequently billed code and surpassing moderate-complexity visits (CPT code 99284). This upward shift was accompanied by corresponding declines at the lower end of the complexity spectrum. The share of low-complexity visits (CPT code 99283) declined from approximately 28% to around 22%, while the combined share of minimal- and straightforward-complexity visits (CPT codes 99281 and 99282) fell from approximately 10% in 2017 to roughly 5% by 2026. Moderate-complexity visits (CPT code 99284) remained relatively stable at approximately 35% throughout the period, suggesting that the primary redistribution occurred between the lowest and highest complexity codes rather than reflecting a uniform upward shift across all code levels. These trends in visit complexity occurred alongside a decline in overall ED volume, as visits fell from 17.5 million in 2017 to 12.4 million in 2025, representing an approximately 29% decrease.[9] One potential explanation is that the lowest severity cases are being cared for in urgent care or other non-ED settings and only the higher severity cases are being treated in the ED.

The overall effect of these shifts in code mix is captured by the average APC weight per visit, which is also displayed in Figure 2 as a dotted black line. This metric increased from approximately 4.6 in 2017 to 5.1 in 2026, translating to a cumulative increase of roughly 11% in average payment weight per visit. This increase reflects changes in code mix alone and is independent of changes in the underlying APC payment rates, such as inflation-related increases.[10]

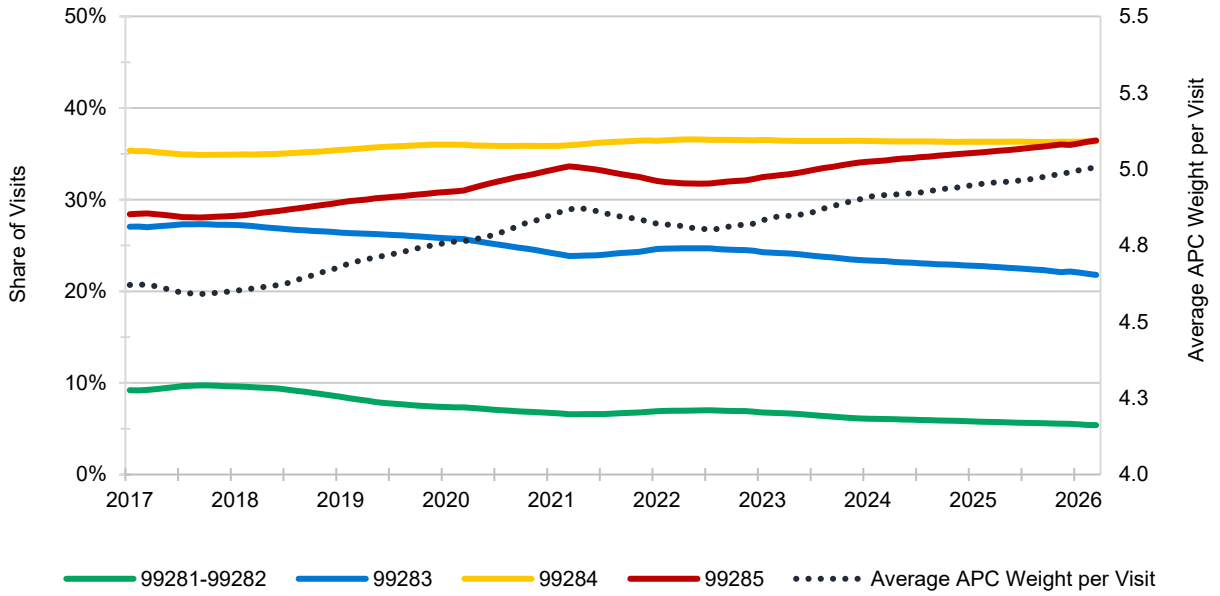
Figure 3 shows the monthly distribution of ED visit codes and the average APC weight per visit as 12-month rolling averages, smoothing short-term volatility and more clearly revealing the underlying trajectory of coding trends over time.[11]

9. KFF. (August 4, 2026). Figure 4, "Spending on physician services and other Part B services accounts for the largest share of Medicare benefit spending." The facts about Medicare spending. Retrieved September 9, 2026, from https://www.kff.org/medicare/the-facts-about-medicare-spending/?entry=table-of-contents-spending-on-medicare-benefits-and-medicare-advantage.

10. CMS updates outpatient hospital payment rates (i.e., the payment per unit of payment weight) annually based on a hospital market basket inflation index. CMS.gov. (July 15, 2026). Market basket data. Retrieved September 9, 2026, from https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data.

11. Average APC weight calculated using 2025 ED APCs by level (5021-5025).

FIGURE 3: ED VISIT DISTRIBUTION BY CPT CODE AND AVERAGE APC WEIGHT PER VISIT, 2017–2026 (12-MONTH ROLLING AVERAGE)



Finally, we quantify the financial implications of this coding trend by estimating the incremental Medicare reimbursement attributable to the ED visit code distribution shifts between 2017 and 2025, holding 2025 payment rates constant to isolate the effect of coding mix alone. We estimate that these code-mix shifts are associated with approximately $4.4 billion in additional reimbursement over the period, representing 8.1% of total Medicare FFS outpatient ED expenditures, independent of changes in patient volume or payment rates. As with all findings in this paper, these results are based on Medicare FFS data, and coding trends and their resulting impacts in Medicare Advantage, Medicaid, and commercial populations may differ meaningfully.

Coding intensity in inpatient care and its impact

Inpatient acute care hospital reimbursement under Medicare FFS is determined by the Inpatient Prospective Payment System (IPPS), under which hospitals receive a fixed payment for each inpatient admission based on the assigned MS-DRG. Each MS-DRG carries a relative weight that reflects the average resource intensity of treatment for patients within that group. The MS-DRG relative weights are applied to a hospital-specific base rate to determine what Medicare pays for a given hospitalization, making these relative weights the payment weight for inpatient hospitalizations.[12] Based on the secondary diagnoses reported for a hospitalization, the MS-DRG system uses three severity levels: cases with MCCs, cases with complications or comorbidities (CCs), and cases without CCs or MCCs. In general, MS-DRGs with CCs and MCCs have a higher weight, so the presence of secondary diagnoses that trigger CCs and MCCs directly increases the payment a facility receives for the hospitalization. The Medicare data suggest that the prevalence of diagnoses that trigger CCs and MCCs has increased over time.

Figure 4 presents the share of inpatient admissions with a CC or MCC secondary diagnosis across 16 Clinical Classifications Software Refined (CCSR) body systems in Medicare FFS inpatient cases from 2019 through 2025, with increases that are both widespread across body systems and meaningful in magnitude.[13]

12. IPPS also includes adjustments for outliers and inliers (short stays and transfers), as well as payment policy like medical education, uncompensated care, and quality measures.

13. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. Clinical Classifications Software Refined (CCSR) for ICD-10-CM diagnoses. Retrieved September 9, 2026, from https://hcup-us.ahrq.gov/toolssoftware/ccsr/dxccsr.jsp.

FIGURE 4: SHARE OF INPATIENT ADMISSIONS WITH A CC OR MCC SECONDARY DIAGNOSIS BY CCSR BODY SYSTEM, 2019–2025

BODY SYSTEM	LONG DESCRIPTION	2019	2020	2021	2022	2023	2024	2025	ABSOLUTE DIFFERENCE	RELATIVE CHANGE
Overall	**Overall**	**10.5%**	**11.7%**	**12.1%**	**12.3%**	**12.4%**	**12.6%**	**12.9%**	**2.3%**	**1.22**
FAC	Factors Influencing Health Status and Contact with Health Services	5.2%	6.5%	6.8%	7.4%	8.0%	9.1%	9.9%	4.7%	1.90
BLD	Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism	11.5%	12.6%	14.0%	14.4%	14.9%	15.4%	16.0%	4.5%	1.40
NVS	Diseases of the Nervous System	16.1%	18.6%	19.2%	20.1%	21.3%	21.8%	22.5%	6.3%	1.39
INF	Certain Infectious and Parasitic Diseases	7.2%	9.3%	10.4%	12.0%	10.5%	10.2%	10.0%	2.8%	1.39
MAL	Congenital Malformations, Deformations and Chromosomal Abnormalities	1.1%	1.1%	1.2%	1.2%	1.3%	1.4%	1.4%	0.3%	1.28
MUS	Diseases of the Musculoskeletal System and Connective Tissue	3.9%	4.2%	4.4%	4.5%	4.6%	4.7%	4.9%	1.0%	1.26
SYM	Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	8.9%	9.9%	10.1%	10.5%	10.7%	10.7%	11.1%	2.2%	1.25
END	Endocrine, Nutritional and Metabolic Diseases	31.7%	35.4%	36.2%	36.4%	36.8%	37.9%	39.1%	7.4%	1.24
INJ	Injury, Poisoning and Certain Other Consequences of External Causes	6.1%	6.4%	6.7%	6.9%	7.0%	7.2%	7.4%	1.3%	1.21
CIR	Diseases of the Circulatory System	38.4%	41.7%	43.2%	43.7%	44.4%	45.0%	46.0%	7.6%	1.20
NEO	Neoplasms	8.5%	8.9%	9.1%	9.3%	9.5%	9.7%	9.9%	1.4%	1.17
RSP	Diseases of the Respiratory System	27.7%	31.7%	31.5%	31.8%	30.9%	31.2%	31.6%	3.9%	1.14
DIG	Diseases of the Digestive System	11.9%	12.8%	13.4%	13.3%	13.2%	13.4%	13.6%	1.6%	1.14
GEN	Diseases of the Genitourinary System	32.6%	35.2%	35.9%	35.9%	35.6%	35.7%	35.7%	3.1%	1.09
SKN	Diseases of the Skin and Subcutaneous Tissue	6.1%	6.2%	6.4%	6.3%	6.4%	6.3%	6.4%	0.3%	1.05
MBD	Mental, Behavioral and Neurodevelopmental Disorders	4.3%	4.7%	4.6%	4.5%	4.4%	4.4%	4.5%	0.2%	1.04

Overall, the share of admissions with a CC or MCC secondary diagnosis rose from 10.5% in 2019 to 12.9% in 2025, an absolute increase of 2.3 percentage points and a relative increase of 22% over the study period.[14] This upward movement was broadly consistent across nearly all CCSR body systems, as illustrated in Figure 5, where the 2025 Q4 values (shown in red) sit above their 2019 Q1 counterparts (shown in green) for every category. In relative terms, Factors Influencing Health Status and Contact with Health Services (FAC) stands out, with an increase of 90% over the period. This was nearly double the increases observed in the next-highest categories: Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism (BLD), at 40%, and Certain Infectious and Parasitic Diseases (INF), at 39%. Several body systems had larger absolute differences, including Diseases of the Circulatory System (CIR), Endocrine, Nutritional and Metabolic Diseases (END), and Diseases of the Nervous System (NVS), increasing by 7.6, 7.4, and 6.3 percentage points, respectively, from 2019 to 2025. Across body systems, the consistent upward movement in CC and MCC secondary-diagnosis rates reflects a broad-based increase in coded complexity, with meaningful financial implications at scale.

Figure 5 provides an alternative view of CC or MCC secondary-diagnosis rates across the same 16 CCSR body systems. It compares 2019 Q1 and 2025 Q4 values indexed to a 2020 Q1 baseline, illustrating how inpatient coding intensity changed before and after 2020 Q1—the period in which the COVID-19 pandemic began in the United States.[15]

FIGURE 5: INPATIENT ADMISSIONS WITH A CC OR MCC SECONDARY DIAGNOSIS BY CCSR BODY SYSTEM RELATIVE TO 2020 Q1 BASELINE

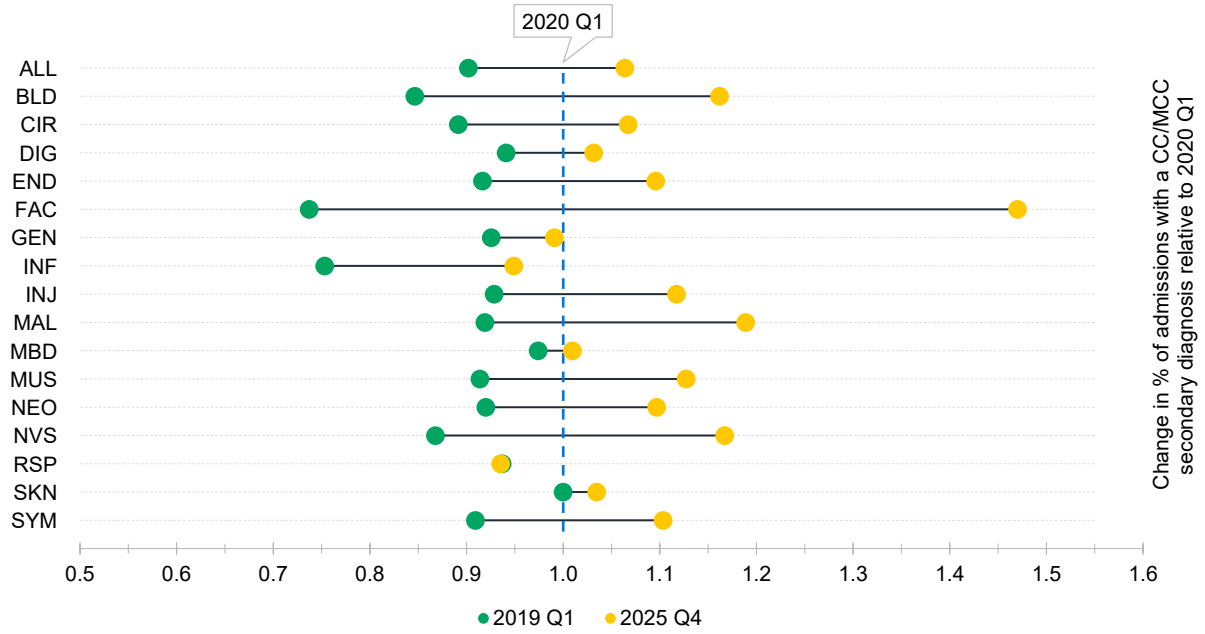


Figure 6 quantifies the financial impact of coding intensity changes within a specific MS-DRG family. The combination of wide payment variation and high volume makes septicemia cases a financially significant and closely monitored diagnosis category in Medicare FFS inpatient coding. While physician documentation remains the foundation of MS-DRG assignment, the growing adoption of CDI technologies helps identify and capture the clinical complexity that drives MS-DRG assignment and, ultimately, the reimbursement level for a hospitalization.

14. CMS.gov. ICD-10-CM/PCS MS-DRG v42.0 definitions manual. Retrieved September 9, 2026, from https://www.cms.gov/icd10m/fy2025-version42.0-fullcode-cms/fullcode_cms/P0387.html.

15. U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response. (January 31, 2020). Determination that a public health emergency exists. Retrieved September 9, 2026, from https://www.aspr.gov/about/law-policy-strategy/emergency-declarations/declarations-public-health-emergency/2020-01-nationwide.

FIGURE 6: MS-DRG CODES FOR SEPTICEMIA CASES

MS-DRG	DESCRIPTION	RELATIVE WEIGHT (2025)	ESTIMATED MEDICARE PAYMENT1(2025)	PAYMENT DIFFERENTIAL VS. MS-DRG 872
870	Septicemia or severe sepsis with MV2 >96 hours	6.957	$45,958	$39,147
871	Septicemia or severe sepsis without MV2 >96 hours, with MCC	1.962	$12,964	$6,153
872	Septicemia or severe sepsis without MV2 >96 hours, without MCC	1.031	$6,811	-

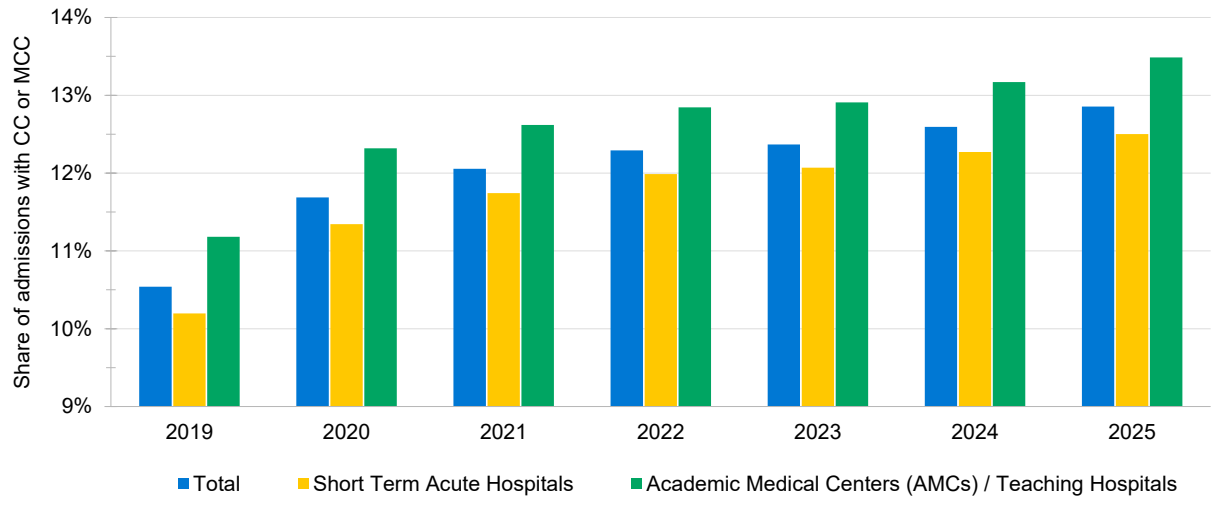
1. Estimated payment based on FY2025 standardized amount and relative weights. Actual payments vary by hospital wage index, disproportionate share hospital (DSH) adjustment, and other factors.

2. MV = mechanical ventilation.

As shown in Figure 6, using 2025 CMS IPPS national average payment rates, moving from MS-DRG 872 (septicemia without MCC) to MS-DRG 871 (septicemia with MCC) results in a payment increase of $6,153, or approximately 90%.[16] When mechanical ventilation (MV) is required for more than 96 hours, MS-DRG 870 is assigned, resulting in a $39,147 payment increase relative to MS-DRG 872. Thus, for high-volume diagnoses such as septicemia, even incremental shifts in the documentation and capture of CCs and MCCs can translate into significant aggregate reimbursement for hospitals and health systems.

Figure 7 shows the growth in CC and MCC secondary diagnosis rates in Medicare FFS from 2019 through 2025, segmented into three categories: Academic Medical Centers (AMCs) and Teaching Hospitals, Other Short-Term Acute Care Hospitals, and an aggregate total. AMCs and Teaching Hospitals are defined as short-term facilities with at least 50 reported interns or residents, while Other Short-Term Acute Care Hospitals are defined as short-term facilities with either fewer than 50 reported interns and residents or no reported count.

FIGURE 7: SHARE OF INPATIENT ADMISSIONS WITH A CC OR MCC SECONDARY DIAGNOSIS BY HOSPITAL TYPE, 2019–2025



16. Amounts are derived from published MS-DRG relative weights and the national standardized amounts, before application of hospital-specific adjusters, such as the wage index or indirect medical education (IME) adjustments.

Figure 7 reveals a consistent gap between the rates for AMCs and Teaching Hospitals and the rates for Other Short-Term Acute Care Hospitals. The former grew from approximately 11.2% to 13.5% over the 2019–2025 period, while the latter grew from roughly 10.2% to 12.5%. The aggregate total across all acute care hospital types increased from approximately 10.5% to 12.9%. The difference in level between these groups is consistent with differences in case mix, and the gap remains roughly constant across the period. The parallel and sustained upward trajectory across both hospital categories suggests that the forces driving rising CC and MCC secondary diagnosis rates are not specific to any single facility type and likely include both the spread of CDI technologies and broader efforts to improve documentation completeness.

Conclusion

The analysis presented in this paper shows that medical coding intensity in the U.S. healthcare system has followed a sustained and measurable upward trajectory, with financial implications for public and private payers, providers, policymakers, and patients. Some of this trend may reflect improvements in documentation completeness, coding accuracy, and recognition of patient acuity, while some may reflect increases in coded severity that are not fully explained by changes in underlying clinical complexity. Payers should therefore analyze their own data closely, particularly in payment systems that rely on coded diagnoses, claim weights, or risk scores, because similar trends could affect payment design, provider reimbursement, contract negotiations, and overall healthcare spending.

Looking ahead, the increasing adoption of AI-assisted CDI technologies may further change documentation and coding patterns as these tools are integrated into clinical and revenue cycle workflows. These tools may improve documentation quality, coding accuracy, administrative efficiency, and revenue cycle performance, but they may also create challenges for payers if the documentation baseline used to calibrate payment systems shifts. If increases in coded severity outpace actual changes in patient acuity and medical service intensity, payment models may require recalibration, monitoring, and governance to remain accurate and sustainable. The industry's challenge will be to preserve the efficiency and accuracy gains promised by these technologies while ensuring that payment weights, risk scores, and reimbursement levels continue to reflect the underlying changes in clinical need and resource use.

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