



MEDICAL SOCIETY OF THE STATE OF NEW YORK
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October 28, 2025

Terry Golash, MD
Senior Medical Director
Aetna Healthcare
20 W 86th St,
New York, NY 10024
Via email: GolashT@aetna.com

Re: Aetna Evaluation and Management (E/M) Program Claim & Code Review

Dear Dr. Golash:

On behalf of over 20,000 physician and medical student members of the Medical Society of the State of New York (MSSNY), we write to urge that Aetna reevaluate its reimbursement policy, Evaluation and Management (E/M) Program Claim & Code Review. The policy appears to state that claims for higher-level services for certain physicians will be downcoded based solely on the data submitted on the claim form. Several physicians have brought concerns to our attention about the implementation of this policy.

MSSNY strongly opposes automatic or unwarranted downcoding of claims, and we strongly disagree that changing the E/M CPT code to a lower level would result in improved claims accuracy.

It is also unclear how Aetna's reimbursement policy is being sufficiently disclosed to physicians, to align with nationally recognized standards for coding and billing, or to consider CPT coding criteria in determination of level of service, and in doing so it increases administrative burden and costs for both physicians and Aetna. Downcoding to a lower level is in effect changing the medical record to a CPT code that was not initially billed by the physician's office. Paying on a code that was never sent could be considered fraudulent as the medical records are not being reviewed in order to make this determination.

To that end, we also believe that this policy may be inconsistent with New York's claims adjudication law (Insurance Law Sec 3224-b) that requires the processing of claims consistent with AMA CPT guidelines and conventions, as well as New York's law (Insurance Law Sec. 3224-a) that requires health plans to provide specific information to providers as to why a claim is not payable.

Though Aetna's Evaluation and Management (E/M) Program Claim & Code Review policy is ostensibly designed to verify billing and coding accuracy for high-level E/M services, we are very concerned that its true purpose may be to control the costs associated with these services. However, the policy has the opposite effect. By having arbitrary downcoding practices that don't reflect AMA CPT coding standards, the policy adds unnecessary complexity to the claims process, forcing physicians to engage in time-consuming appeals and generating additional administrative workload. Meanwhile, Aetna will incur the administrative expense of processing appeals and managing disputes, undermining any intended cost savings.

Industry revenue cycle data estimates it costs physician practices between \$40-\$75 per claim to appeal and costs payors between \$50-\$150 to process each appeal, highlighting the significant administrative expense both physician practices and Aetna incur under its current policy. In practice, these policies function less as tools to promote accuracy and more as barriers designed to disincentivize billing for higher level E/M services—even when clinically appropriate. This approach also introduces avoidable friction with physician practices into the process, erodes trust between providers and plans, and exacerbates the challenges of delivering high-quality care in a resource-constrained environment.

Moreover, we note that the policy is being applied to "select providers". We are requesting further information regarding how providers are being "selected" for this additional review. What cohort of physicians are these "select providers" being compared against? Will these physicians have a meaningful opportunity to challenge this "selection"?

As you may be aware, both New York's Public Health Law Section 4406-d and Insurance Law Section 4803 contain provisions calling for physicians being compared to be "regularly informed of information maintained by the insurer to evaluate the performance or practice of the health care professional"...and that "Any profiling data used to evaluate the performance or practice of such a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population." Furthermore, it provides that "Upon presentation of such information or data, each such health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the professional's profile and to work cooperatively with the insurer to improve performance.

The bottom line is, if a physician is "selected" for this additional review based upon comparison against other physicians, they should have a meaningful opportunity to challenge this designation.

In summary, we have serious concerns with the significant administrative burdens and costs for both physicians and Aetna that have resulted from implementing this policy and strongly urges Aetna to reevaluate it. All of these concerns underscore that Aetna's policy hampers physician practices already grappling with clinician burnout, workforce shortages, and rising practice expenses due to inflation. We



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believe a more constructive and collaborative approach—such as leveraging provider education on appropriate coding practices or focusing on education of outliers, rather than broadly penalizing physicians who are billing appropriately in accordance with AMA guidance—would be more effective and sustainable in the long term.

Again, we urge Aetna to retract this policy that could be inconsistent with New York State's claims adjudication and network participation laws. I welcome the opportunity to meet with you to discuss reversal of this policy as well as other efforts on which we can partner with you to improve of the health of your enrollees and our patients.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "DJ, MD", is placed over a light gray rectangular background.

DAVID JAKUBOWICZ, MD
MSSNY President