

July 8, 2024

Members of the California Delegation,

On behalf of the American College of Emergency Physicians (ACEP), California ACEP, and the California Medical Association, and the nearly 90,000 members we collectively represent, we write to express our deep concerns with Aetna's recent update to its Claim and Code Review Program for emergency services that may significantly affect patients in need of lifesaving emergency care.

Beginning on July 8, Aetna will implement a new policy to “we will review physician and facility claims for Emergency Room Services, and we’ll evaluate the proper use of the Level 4 and 5 E&M [Evaluation and Management] coding” that physicians submit, and “may adjust your payment if the claim details don’t support the level of service billed” for commercial, Medicare Advantage, and student health policies. While Aetna has set this as a national policy, its use has so far been noticed in California.

Despite multiple requests by different affected parties, Aetna has refused to share the actual policy language itself. From the description of the policy in the notice alone, there are already glaring problems. First, federal laws like the [prudent layperson \(PLP\) standard](#) prohibit the use of final diagnosis codes to determine payment or coverage, and the PLP standard applies to the service lines cited in this notice. More than 40 states, including California, also have their own PLP standards that may provide even broader protection against the final diagnosis being used for reimbursement policy.

California law, as is true in many states, requires prompt payment of emergency physicians claims and does not allow for delay based on a coding dispute. It is worrisome that Aetna may be intending to use this policy to delay all Level 4 and 5 E&M code payments. This could lead to a significant funding problem for the emergency care safety net as an aging population with complex chronic conditions has led, among other things, to a higher acuity patient mix in the ED. As well, the notice provides little to no detail on what Aetna believes constitutes proper use of the Level 4 and 5 E&M codes.

As background, there are five levels of physician ED care, which are documented and billed for using CPT codes 99281 - 99285. These ED codes require all three key components (patient and family history, a physical examination, and the physician's medical decision-making) to be met and documented for the level of service billed in the emergency physician's claim. Patients are required to be categorized based on the severity of their presenting problem(s): for example, a Level 4 (99284) visit is a severe problem that requires urgent evaluation that will, without treatment, have a high chance of extreme impairment (however, does not pose an immediate threat to life or to physical function). A Level 5 (99285), on the other hand, is an immediate, significant threat to life or physiologic functioning. An additional and important point to be aware of is that emergency physician services are coded and billed separately by the physician group from the facility fee, which is billed by the hospital and coded in a different manner.

It is concerning that Aetna is conflating physician and facility coding which have little to nothing in common with one another. Facility coding, in short, measures hospital resource allocation, e.g. equipment and medical supplies, and

expenditures of nursing and staff resources. Moreover, there is no national standard for hospital outpatient facility coding.

The physician coding standards, by contrast, were substantially changed effective January 1, 2023, and their emphasis is on the medical decision making (MDM) regarding the patient's history of the presenting illness. The physician standards were developed jointly by the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) and have been adopted for all government and commercial health plans. The "2023 document guidelines" (DGs) do not measure the extent or degree of hospital resource allocation. So again, the physician DGs and the facility coding guidelines have essentially nothing in common and should not be used as a basis for matching facility and professional fee levels.

ACEP urges the California Congressional Delegation to request that prior to implementation, Aetna provide a clear and detailed description of these new policies described above to ensure this is not simply another attempt to delay payment or downcode services provided by emergency physicians and that this policy does not violate the critical patient protections established by Congress in the federal prudent layperson standard. This policy will have significant impacts upon emergency physician groups that are already facing considerable financial hardships, potentially destabilizing the health care safety net and severely limiting access to the lifesaving emergency care that Californians need and deserve.

Should you have any questions, please do not hesitate to contact Laura Wooster, MPH, ACEP's Associate Executive Director of Advocacy & Practice Affairs at lwooster@acep.org, Elena Lopez-Gusman, California ACEP's Executive Director at ELopez-Gusman@californiaacep.org, or Elizabeth McNeil, California Medical Association's Vice President of Federal Government Relations at emcneil@cmadocs.org.

Sincerely,



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