HEARTBEAT

THE BIMONTHLY NEWSLETTER OF THE ALASKA STATE MEDICAL ASSOCIATION October 2025

PRESIDENT'S COLUMN

The Alaska State Medical Association held its fall retreat on October 1, 2025. It was attended both in person and on Zoom. I would like to say thank you very much to all who attended.

The agenda included the financial reports of the Alaska State Medical Association and review and approval of next year's budget.

Rhene Merkouris, MD

We have made many adjustments in order to run as lean as possible. We have one full-time employee, our CEO Pam Ventgen, with all other jobs sourced out as part time or volunteer. Currently we are able to continue functioning due to membership fees, donations and grants. Our operating expenses will be reviewed and adjusted in the coming executive board meetings. Any grants or other ideas that become known to you please contact ASMA and let us know.

The Association's Bylaws were amended allowing a Resident representative on the board to encourage continued engagement by the younger generation of physicians. There were also housekeeping changes to bring the bylaws up to date that were suggested by our ASMA attorney. All were approved by the membership.

The issue of illegal down coding by Aetna was brought to light by the excellent informative presentation by billing manager, Aubrey Byrne. She had identified that Aetna had begun down coding 99514 and 5 VISITS WITHOUT CHART REVIEW REQUESTS OR CHART NOTES. This action, which does

Merkouris Continued Page 3

The issues in 2025 attacking the practice of medicine have at times become overwhelming. With the dismantling of NIH, changes at HHS, CDC, vaccine delivery and institutional research, who can keep up? Continued education of our patients is one avenue to combat misinformation. It can be exhausting but necessary. There are many counseling vaccine guidance and coding bulletins on AMA and your Professional society sites. It is important as new guidelines emerge and change since "winter is coming" or actually, already here.

There have been more distressing reports of physicians unable to make ends meet and electing early retirement, changing to out-of-state or locums practice. For our legislators to listen we need these stories. Let us know what you are experiencing.

There is much you and ASMA can do! For ASMA to be effective with the state legislators and Alaska Division of Insurance and to help our patients to receive their referrals and meds which are also being denied **we need YOU TO TELL**

ASMA has joined the federal antitrust litigation against MultiPlan (recently rebranded as Claritev) and major insurance carriers over alleged price-fixing that has shortchanged healthcare providers for nearly a decade.

MultiPlan processes more than 80% of out-of-network claims nationwide and has allegedly forced physicians to accept increasingly low payment amounts for out-of-network services. This has put practices at financial risk and limited patient access to care.

We are joining hundreds of physicians and the American Medical Association to fight for fair compensation and end this anticompetitive conduct.

Healthcare providers who believe they have been affected by MultiPlan's alleged scheme can receive a free case evaluation today: https://www.napolilaw.com/en/multiplan/

Support ASMA

You can help support ASMA by using the QR code to donate to your state medical association and its valuable services. Or send a check to ASMA at 4107 Laurel Street, Anchorage, 99508. Thank you.

SCAN TO DONATE

ASMA Website Info:

- For those that have not logged in yet, the site did not carry over your password. You **WILL** need to reset it in order to login.
- If you don't have an address in the "personal" field you will not receive mailings. Please login to update your profile.
- Physician images were **not** imported to the new site so please be sure you log in and upload a new photo for the OMD (Online Medical Directory).
- The system currently does not support Company Admin's uploading individual physician photos. You may email photos to ASMA@asmadocs.org, but please include the physician name and company so that we can be sure we're uploading to the proper

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not follow CMS or AMA policy is unethical and denies fair reimbursement and physician autonomy ultimately affecting patient care. It also increases costs by necessitating appeals and delaying payment.

Many old billing programs do not show what was billed vs what was paid but only the code that was paid, allowing the big insurance companies to exploit this loophole. Aubrey has a new billing system that shows what was billed and at what level it was paid. This will be very difficult if not impossible to catch without knowing it is happening. Aubrey's presentation is included in this newsletter so it can be shared with your coding/ billing department. For Aubrey's practice with her scrutiny for 90 days, 41% of the time her 99515s were downcoded to 99513 and 23% of 99214's. After she Identified these and wrote multiple letters and appeals to AETNA ultimately 24 out of 25 were eventually paid at the proper level. This work took 35% of her claim-chasing time.

These actions effectively deny the complexity of physicians' time and effort, subordinating our clinical judgement to an insurer's review. When physicians face these excessive burdens, they will drop Aetna and Cigna forcing the patients to face out of network costs for care making our patients the ultimate sacrificial lambs.

In light of these activities, have your billers, office managers and colleagues call or email Aetna with these talking points:
I am urging you to follow the talking points to phone or email AETNA about these changes.

Hello, this is Doctor (name). I am calling to express concern about Aetna's evaluation and management CCRP (Claim and Code Review Policy) that took effect March 1,2025.

This policy is unlawful and opaque. It automatically down codes level 4 and 5 visits without disclosing the criteria used - Contrary to laws requiring transparency and payment rules.

It also conflicts with AMA and CMS coding standards, which base E/M levels on documented time or medical decision making. Automatically down coding undermines the integrity of the E/M coding guidelines and denies Fair Payment for complex medical care.

This policy costs employee time and effort scrutinizing claims, submitting appeals and tracking all these appeals, most of which are ultimately paid after review of the records.

I urge Aetna to rescind this policy and instead focus on constructive solutions like provider education and targeted outreach to true outliers.

Can you direct me to the person responsible for addressing physician feedback on this policy?

Sincerely,
(Name, Title)
(Practice)

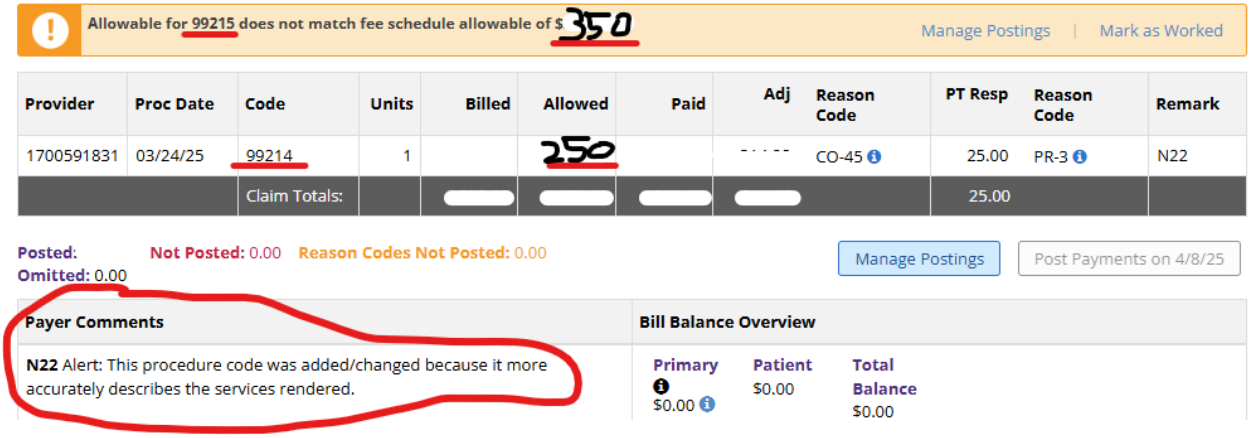
Your letters, phone calls and feedback do make a difference.

Aetna is Shorting Physician/Provider Payments Without Requesting Documentation

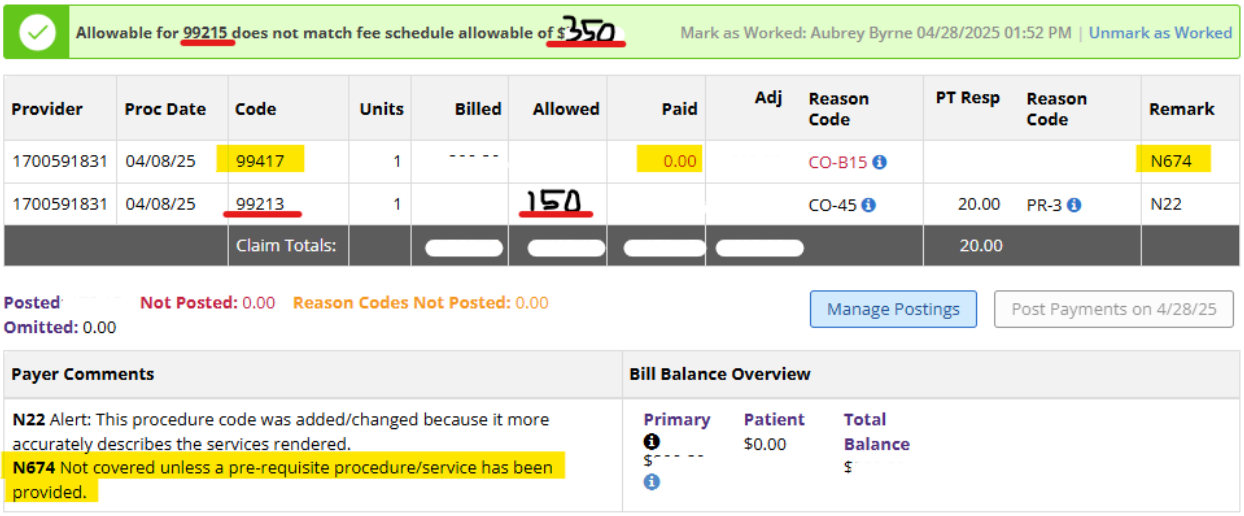
By Aubrey Byrne, CCS-P
Billing Manager for Borealis LIFE, LLC Anchorage, AK

Aetna is shorting our high level office visit payments without requesting documentation.
And because they are simply replacing your code with their own, you may not even have noticed! I am the billing manager in a local practice. I found this on payments for our office starting 4/1/25. Aetna replaced our level 4 and 5 office visit codes with level 3 or 4 codes instead, and then paid us for their lower level code. The payments included Remark N22: "Alert: This procedure code was added/changed because it more accurately describes the services rendered."

Example of a downcoded Aetna payment:



And for extended time visits, this added the insult of making the extended time code invalid which cut our payments even more as shown in the next picture:



This made me angry. An insurance company cannot just recode visits without chart notes any more than we (the billing/coding staff) can, that's called Fraud. This practice goes against all national coding guidelines, insurance claims processing standards, and local and national fair claims processing laws. These guidelines, standards, and laws from organizations such as the AMA who publishes those procedure codes, CMS, NAIC (the National Association of Insurance Commissioners, ERISA (the Employee Retirement Income Security Act) federal law, and Alaska state law all require coding to be based on documentation, and they require that medical offices be provided with specific information and opportunity for review in the case of a denial. In other words, due process. NBC News summed up the problem of this new downcoding practice by calling it "Guilty Until Proven Innocent" in a recent article of that title.

Byrne continued Page 5

I emailed my peers at the Alaska Medical Group Management Association (MGMA) and found out that many Alaskan offices were affected by this new policy, not just my office. The only way to be fully paid for each automatically-downcoded claim is to send a Reconsideration Request to Aetna with chart notes. This is a time-consuming process that for me personally takes about 20 minutes per claim including posting the incorrect payment, printing the necessary materials, composing the request, faxing it, and posting the reprocessed claim which at this point is hopefully paid correctly. If not, the whole process repeats again.

Next, I emailed Lori O'Banion, our Aetna Alaska Senior Network Manager, cc'ing the Alaska Division of Insurance, MGMA, and AS-MA. I informed her about this new practice, and I advised that it is both unethical on Aetna's part to cut payment for coding without reviewing chart notes and unsustainable for us as medical providers to have to appeal every single one of these claims in order to be paid properly. She responded by providing the documents that Aetna provided us, supposedly notifying us of this material change in our payment. They are pictured below:

December 2024

OfficeLink Updates™

aetna®

Welcome to the latest edition of OfficeLink Updates (OLU). As always, we provide you with relevant news for your office.

90 Day Notice / Payment & Coding section of newsletter:

Claim and Code Review Program (CCRP) update

We might have new claim edits for our commercial, Medicare and Student Health members. You can view them on Availity®.

This update applies to our commercial, Medicare and Student Health members.

Beginning March 1, 2025, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **provider portal on Availity**.*

For coding changes, go to Aetna Payer Space > Resources > Expanded Claim Edits.

There was nothing in the Expanded Claim Edits Document that the article referred to that was dated 3/31/25, but long story short the document does have an Evaluation and Management Policy Section with an entry dated 10/1/2018 that reads as follows:

We evaluate the appropriateness of levels 4 and 5 E&M codes to determine whether the level of service billed correlates to the intensity of the service not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The v the primary influence upon which a specific level of service is billed. The documentation in the medical record should support the CPT and ICD codes r form.

We follow CMS and AMA guidelines for documentation and coding services.

This was not adequate notification of such a major payment policy change in my opinion. Lori also provided me with Aetna's Evaluation and Management Program Claim and Code Review document, an excerpt of which is below, where Aetna tries to justify their policy by stating:

aetna

Evaluation and Management (E&M) Program Claim and Code Review

Overview

The Evaluation and Management (E&M) Program is part of the Claim and Code Review Program. We contract with a vendor to review coding for E&M services. For select providers, our vendor will evaluate the appropriateness of levels 4 and 5 E&M codes to assess if the level of service billed matches the intensity of the service and the severity of the illness. The edits are not clinical. They are based on external coding guidelines. Our vendor uses certified coders who review the claim billed and the member and provider claim history to make the edit decision.

Certified Coders cannot review for coding without chart notes, so this makes no sense. At this point, I also emailed our local Chapters of the American Association of Professional Coders and the American Hospital Information Management Association so they could make their members aware of this problem, in addition to the organizations I included on my email to Lori at Aetna. Then I emailed Lori again stating that this was inadequate communication to make us aware of this material change in payment policy that adversely affects us, this was NOT being done according to CMS & AMA Standards that Aetna states they follow, that nowhere in their policy does it say they are going to downcode & short our pay without requesting documentation, and that doing so is NOT permitted without documentation according to CMS & AMA Guidelines. My closing paragraph stated:

> Lori, please speak up for us against Aetna on this new policy of downcoding office visit payments without documentation. It is unethical and imposes an unreasonable administrative burden on us, forcing us to repeatedly prove compliance with coding rules we are already legally bound to uphold.
>
> Aubrey Byrne, CCS-P, Billing Manager
> (907) 206-4689, option 5
> Borealis LIFE, LLC
> 2501 E 42nd Ave, Anchorage, AK 99508
> aubrey.byrne@borealislife.org
> Borealis L.I.F.E.
> Laparoscopic Institute for Fibroids & Endometriosis

She gave no further response.

However, a colleague of mine who had also contacted Lori said that she told them this program would only be temporary. So, after ninety days of wrestling with these downcoded payments, I compiled some data from our practice. I found that 40% of our level 4 & 5 office visits were being down coded. Three-quarters of our extended time visits were down coded. A full third of my old claim chasing time was now spent JUST on these Aetna downcoding claims. For some perspective, I am the only biller in my office for our three providers, one of whom is an MD who performs both clinical and surgical duty and 2 of whom are advanced practice providers who specialize in both primary care and bioidentical hormone replacement therapy. Out of the twenty-five reconsiderations I sent during this time, all but one were granted. I sent a Second Appeal for that one which was later granted.

CPTs Paid by Aetna over the 90-day period
4/1/25 (the start of Aetna's fraudulent downcoding without documentation) - 6/30/25

CPT	Total Pd	Pd Correctly	%	Paid Short	%	Hrs Spent Appealing @ 20"/Appeal & posting Appeal Result
99204	4	4	100%	0	0%	n/a
99205	5	4	80%	1	20%	0.33
99214	13	10	77%	3	23%	1.00
99215	32	19	59%	13	41%	4.33
w/ 99417	11	3	27%	8	73%	n/a
Totals	65	40	62%	25	38%	5.67

Notes on these 25 Appeals:
*As of 7/28/25, 1 Appeal denied out of the 25 submitted, resulting in another 20" spent on 2nd Appeal
*On one of the 99215/99417s, Aetna reprocessed and paid at the 99215 level but failed to change the code back to 99215, so had to Appeal again for pmt on acompanying 99417
*About 6 hours/month spent Appealing these fraudulently downcoded claims.
--An office of our size spends about 2 days a month chasing old claims.
--This is 35% of my claim-chasing time JUST on these Aetna claims

I emailed Lori again with this data, asking how much longer they were going to continue this practice. Her response was: We anticipate this program and data will be reviewed on an annual basis.

Before I go into the final actions I've taken & the resources for your own fight, I want to share a few of my personal feelings on this. I understand that the need to control cost is important in healthcare with costs rising ever higher, making it more and more expensive for both our patients and for us (because we need healthcare too). However, doing so in this manner is unacceptable. It is, again in my opinion, sneaky & underhanded. It is yet another example of an insurance company trying their best NOT to pay us for our work. Not only does this affect OUR ability to be fully paid in a timely and efficient fashion, it also affects our ability to bill the proper amount due to the PATIENT in a timely manner. This affects our patient care, as prompt & accurate billing is also a big part of a patient's medical experience. The only one who profits from all of this is AETNA who gets to hold onto our money that much longer, earning that much more Interest. And they know that a percentage of us won't catch this short payment, a percentage of us won't bother to fight it, and that they can even further delay or deny payment on a percentage of the claims that we do fight.

It is also interesting to note that all of the affected Aetna plans I looked at when I analyzed our practice's 90-day data were Self-Funded, therefore governed by the federal Employee Retirement Income Security Act of 1974 (known in acronym as ERISA), and not by Alaska State law. Either Aetna is deliberately trying to bypass the Alaska Insurance Commission oversight, or there are just a lot of self-funded plans in Alaska. Regardless of that interesting information, the claims processing delays this new procedure brings affects thousands of Alaskans. Plans in our clinic's 90-day data included:

Alaska Care (which is the State of Alaska)
Providence Hospital
Costco
Odom (the Coca-Cola) Corporation,
The Federal Employee Health Benefit Plans that are administrated by Aetna (anyone working for a Tribal Corporation for example can select one of these Aetna plans for their health insurance)
Lynden Transport
Anchorage School District

During this fight, I also found out that this is a National Program not only by Aetna, but that Cigna was set to start an automatic downcoding program on 10/1/25. There are many other State Medical Associations waging their own fight against this unjust practice. My friends, we do NOT want this to become a new standard insurance practice.

I believe that the best way to stop Aetna & others from following their footsteps is to hold them FINANCIALLY ACCOUNTABLE & make this practice UNPROFITABLE. Having said that, let me make it clear that we DO NOT want to run Aetna out of town. We need the competition so that other large payers such as Blue Cross do not gain even more market share & power and start other disadvantageous practices.

What we want from Aetna is for them to

Immediately cease this practice / demand that they conform with State & Federal Law by requesting chart notes PRIOR TO making any payment or coding adjustments to our claims
Review & Correct all affected claims
Pay us back for all of our time
Pay us interest for the payment delay
Any other Punitive Fees we can tack on there to make this UNPROFITABLE

AND FURTHER, we need the Alaska Division of Insurance to have jurisdiction over Self-Funded Plans so that we can better fight issues like this, as thousands of Alaskans have Self-funded plans! According to our US Constitution, State Laws can't over-ride Federal, but we can be stricter, and we are. Alaska actually has a Statute that specifically states insurance companies cannot unilaterally change our codes. We need to close that loop-hole for Self-Funded Plan jurisdiction so that we can better fight them on these issues.

I sent another email filing a Formal Complaint against Aetna to the Alaska Division of Insurance, the US Dept of Labor Employee Benefits & Security Administration (who enforces those Self-Funded Plans), AHIMA, AAPC, MGMA, & ASMA so that our local coding and medical organizations were in the loop, and all of the health plan administrator emails I could find for the affected plans that use Aetna.
Excerpt from Formal Complaint email:

> We, like many medical offices in Alaska, are a small business. This conduct has:
>
> - **Compromised patient care** by diverting billing resources to this high volume of disputes.
> - **Imposed a disproportionate administrative and financial burden** on our small medical practice.
> - **Bypassed due process** in claims review, undermining transparency and compliance with industry norms.

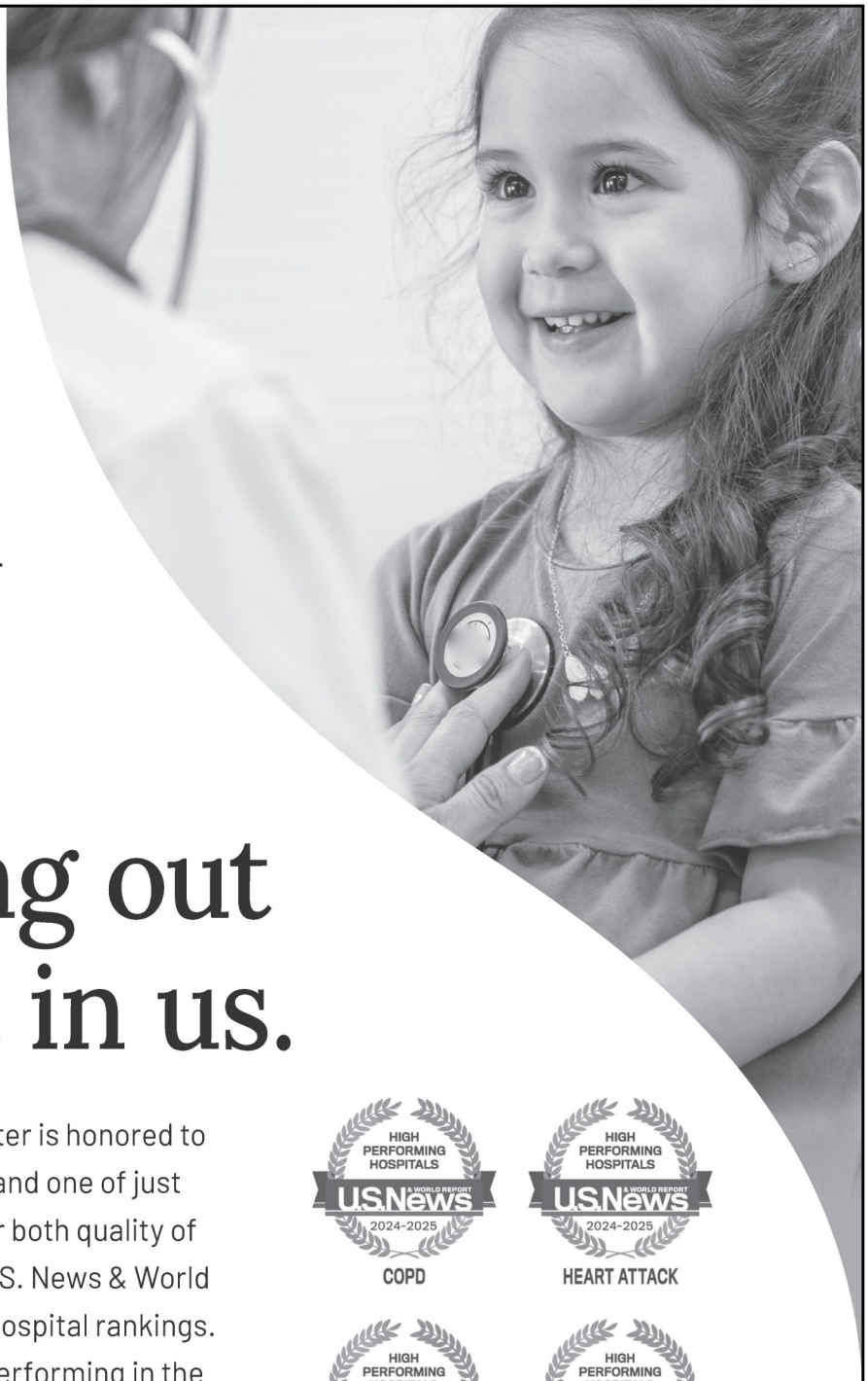
A few organizations responded to my email, their contact info is below:

Alaska Division of Insurance---
They are awesome and responded to all of my emails, but could not help with our Self-Funded plan claims
Insurance@alaska.gov
Shauna Nickel, Consumer Services Supervisor,
Shauna.nickel@alaska.gov

US DOL EBSA---this guy is also awesome, I have worked with him on other Self-Funded plan claim issues. He is currently helping us open a case against Aetna but is limited by the current federal government furlough:
Clive Mitchell, Sr Benefits Advisor
Mitchell.clive@dol.gov

Federal Employee Health Benefit Plans---she responded to me offering to help and making sure she had jurisdiction, but I did not hear back after that initial response
Erika Jacobs, US Office of Personnel Mgt, Federal Employee Insurance Operations
Erika.jacobs@opm.gov

Byrne continued Page 10



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HIGH PERFORMING HOSPITALS U.S.News & WORLD REPORT 2024-2025 COPD

HIGH PERFORMING HOSPITALS U.S.News & WORLD REPORT 2024-2025 HEART ATTACK

HIGH PERFORMING HOSPITALS U.S.News & WORLD REPORT 2024-2025 HEART FAILURE

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HIGH PERFORMING HOSPITALS U.S.News & WORLD REPORT 2024-2025 STROKE

Lori from Aetna called me on 10/1/25, the morning that I gave a presentation on this issue to the Alaska State Medical Association and six months after Aetna started downcoding our office visit claims in Alaska, to let me know that the Coding "Review" Program for our office will end on 10/26/25. She said that only certain providers who had high utilization rates of high-level office visits were flagged for this program. I told her my concern that some offices may not even be catching these payment shortages, but she assured me that plenty of offices were catching it as she was working with many offices on this issue. She said we passed pretty much all of our Appeals these past 6 months. That normally they conduct the program for a year and then review the data, but she went ahead and expedited the review for our office. My friends: making noise really does help, let us not take this quietly.

As a final word, I wanted to pass along a few high-level office visit **coding tips** to help your offices pass your Reconsiderations while you fight this issue:

Coding may be based on Medical Decision-Making
OR Time
And may be different for each visit

Medical Decision-Making:

there are 3 elements to consider (only need 2 of 3 to decide the level)

Problem:

Chronic w/ exacerbation (level 4)

vs Chronic w/ SEVERE exacerbation (level 5)—make sure you chart severity

Data:

this one can be tough. Make sure you note if you reviewed outside notes or tests, there is no assumed relationship

Medical Decision Making:

Rx drug management: self-limited is level 3, Chronic is level 4

Decision on Surgery: level 4, W/ RISK FACTORS is level 5

Time:

Make sure you document **how much time** on **each task** & **what was discussed** if time was spent on discussion

Ex: spent 5 minutes prepping for visit, 5 minutes on medically necessary history & exam, 20 minutes discussing (insert what you discussed here if it is not already documented in your chart note), 5 minutes prepping Orders, & 5 mins charting

If you have a border-line time (such as the 40-minutes in the example above which is the lowest time for a level 5 established patient office visit which is defined as 40-55 minutes), think about coding at the lower level.

Minutes of the Fall Meeting of the General Membership October 1, 2025

Call to Order: The meeting was called to order at 5:34 pm by President Dr. Merkouris.

Board of Trustees in attendance: Drs. Foland, Johnson, Compton, Colescott, Malter, Powell, Sheufelt, Mitchell, Panko, Cooper and PA Froiland.

Staff present: Jardell, Heyman, and Ventgen.

Guests present: Jeff Davis, consultant.

Members Present: Jean Tsigonis, Betsy Douds, Jenny Fayette, Megan Hall, Lisa Alexia, James O'Malley, Sharon Schaefer, Eric Miknich, Irina Grimberg, Ilona Farr, Lauri Montano, Abraham Tsigonis, Mark Wever, Peter Lawrason, John Finley, Ashok Rai, Jody Butto, Robin Holmes, Candace Hickel, Jeff Moore, Camilla Sulak, Byron Perkins.

Minutes: The minutes of the October 2, 2024, General Membership Meeting were approved after a motion by Foland that was seconded by Powell.

Guest Presentation:

Aubrey Byrne, CCS-P, Billing Manager for Borealis Life, gave a presentation on recent behavior by Aetna with down coding Evaluation and Management codes without reviewing medical records. These claims have been appealed and virtually all have been paid at the original rates but this takes significant staff time to resubmit and follow these claims. Recent news articles indicate that Cigna is beginning to do the same. Aetna's down coding is mostly in ERISA plans which are not covered by the State Division of Insurance.

Minutes continued page 11

There is significant concern about this behavior and that practices may not catch the downcoding since insurers are paying the proper amount for the lowered code. If the biller does not recognize that the paid code is different from the billed code, they may miss the opportunity to appeal the claim. Aubrey agreed to supply more information for publication in the next Heartbeat.

Bylaws Amendment – Ms. Heyman explained the proposed changes to the bylaws which include creating a position on the Board of Trustees for a resident physician (from any of the residency programs in Alaska), some minor clean-up language for things like electronic meetings, and the addition of a category of membership for non-physician corporate sponsors. After discussion it was moved by Sulak and seconded by Wever that we table the discussion of corporate members/sponsors and vote on the rest of the proposed bylaws amendments. There was unanimous agreement to table this portion of the amendment.

Upon a motion by Foland, seconded by Powell, the remaining bylaws amendments passed unanimously.

ASMA Business: ASMA's financial position was reviewed. With failure of the 80th percentile litigation and the current atmosphere in Juneau, ASMA's contract with Jeffrey Davis was put on hold. Additionally, Cassie Jeanes, office manager, resigned in July. Her duties have been covered by Pam in addition to contracting with Kim Pawlak for website and membership management and Teresa Curran, bookkeeper. Contract services have worked out to be significantly less expensive than Cassie's full-time salary. As long as membership remains stable, ASMA is a bit more secure for the next 18 months.
Dr. Foland also mentioned that the PHC has helped innumerable physicians over the many years but without ASMA's backing the PHC would cease to exist. Dr. Sulak suggested that physicians encourage their specialty associations to encourage concurrent membership in ASMA to support physicians, patients and medical practices in the state.

Legislative Involvement:
Mr. Jardell reviewed the status of things in Juneau. The relationship between the legislature and the governor is not collegial. The governor has vetoed a record number of measures passed by the legislature and that is expected to continue.
The likelihood of success of a replacement for the **80th percentile** rule is slim and even if it does pass, there is some likelihood of a governor's veto. We will continue to educate legislators on the need for a replacement, but this effort may need to be pushed to the following year. Network adequacy was our secondary effort last session. Legislators had a hard time understanding this concept since it has no immediate threat. We will probably not put a lot of effort in this bill next year.
Scope of practice bills are of high interest. Rep. Ruffridge seems to have lessened his support for broad **pharmacist** prescriptive authority. The **naturopath** bill will be discussed at some length, but we should be able to defeat that bill. The ASMA board has been working with **PA** representatives and both sides believe they have reached language that both physicians and PAs can live with. This middle ground is similar to North Dakota's language where a PA working in a physician-led team setting (clinic, facility, hospital, etc.) would not have to identify a specific collaborating physician since they presumably collaborate with many physicians in the practice setting.
Tort reform will need to be addressed at some point. Since the recent malpractice case that succeeded in a substantial "recklessness" award, most subsequent cases have claimed reckless behavior. Reckless is not subject to the established caps on non-economic damages and is not covered by professional liability insurance coverage. Plaintiffs' attorneys are well funded and frequently chair the judiciary committees in the legislature. ASMA needs to begin work on updated tort statutes.

Medical Board concerns
Recent actions of the medical board have caused varying levels of concern. There is some interest in looking at ways the physician community might have input on who is appointed to the medical board. When the Alaska constitution was written it gives significant authority to the governor. There appear to be few, if any, ways the physician community might have input. When physicians write letters concerning the board's recent stance on gender-affirming care, letters should be about the scope of authority of the board rather than about any particular issue.

Next meeting of the General Membership will be on Wednesday, May 6th, 2026.

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