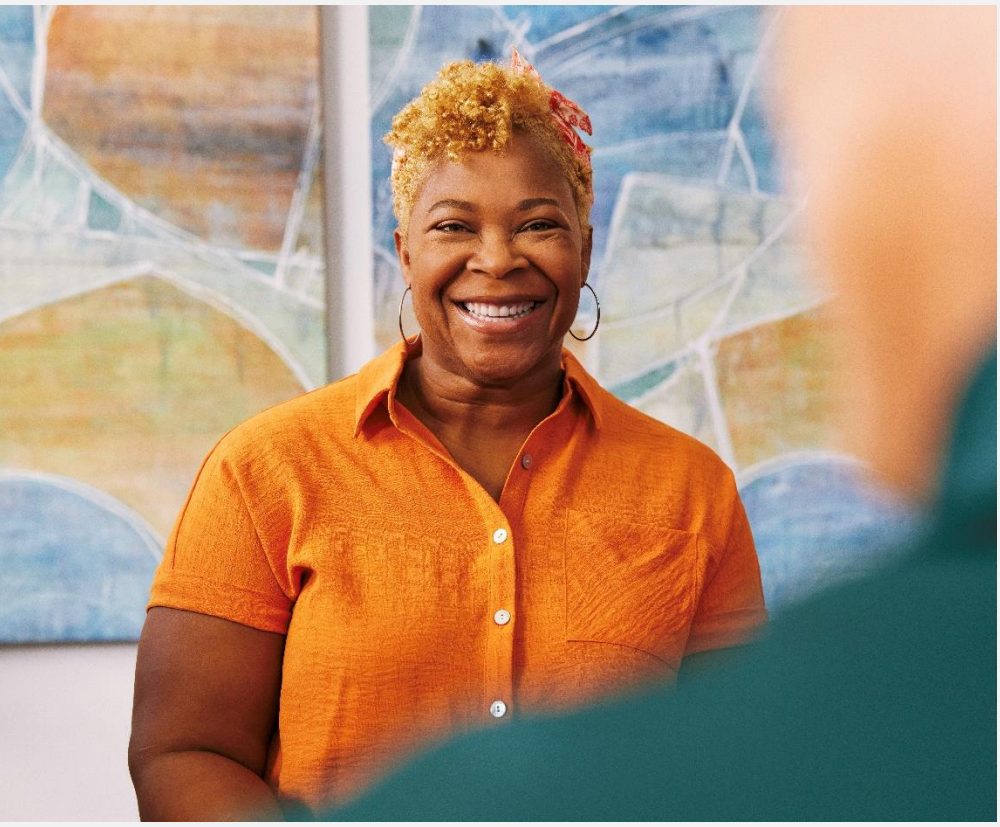
December 2025

# OfficeLink Updates™

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



## HIGHLIGHTS IN THIS ISSUE

**Certain infertility PAs now include associated drugs**

For certain procedures, a single prior authorization (PA) request will cover the procedure and the associated drugs. If we approve the request, you'll just need to send the prescription to the pharmacy.

**Changes to vision coverage under the Aetna MA Individual plan**

Starting in January, Aetna MA Individual plan members must see an EyeMed provider for routine vision benefits. Be sure to check eligibility and verify whether you are an EyeMed provider.

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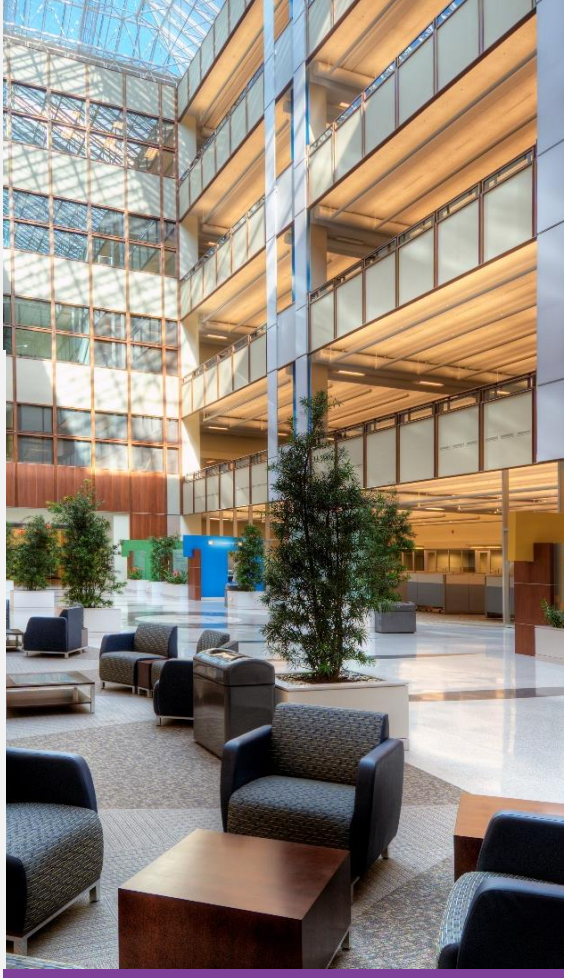

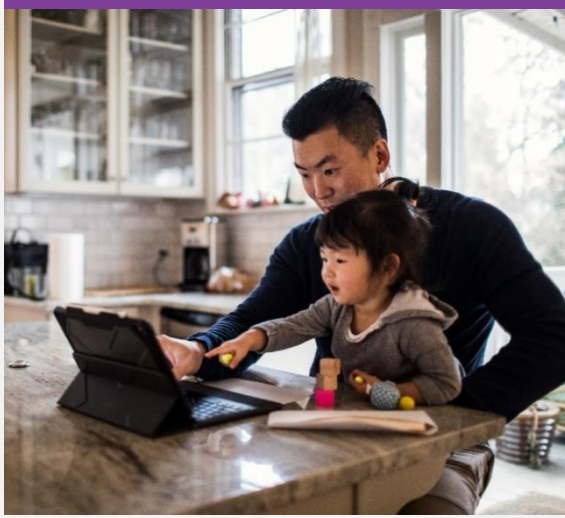

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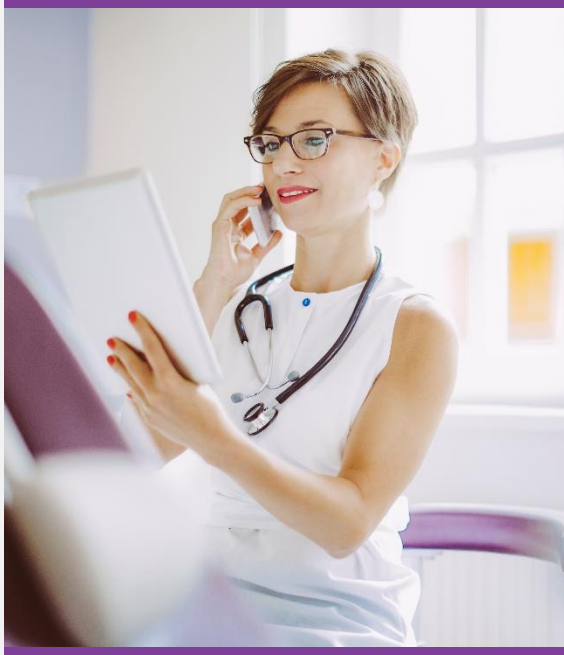

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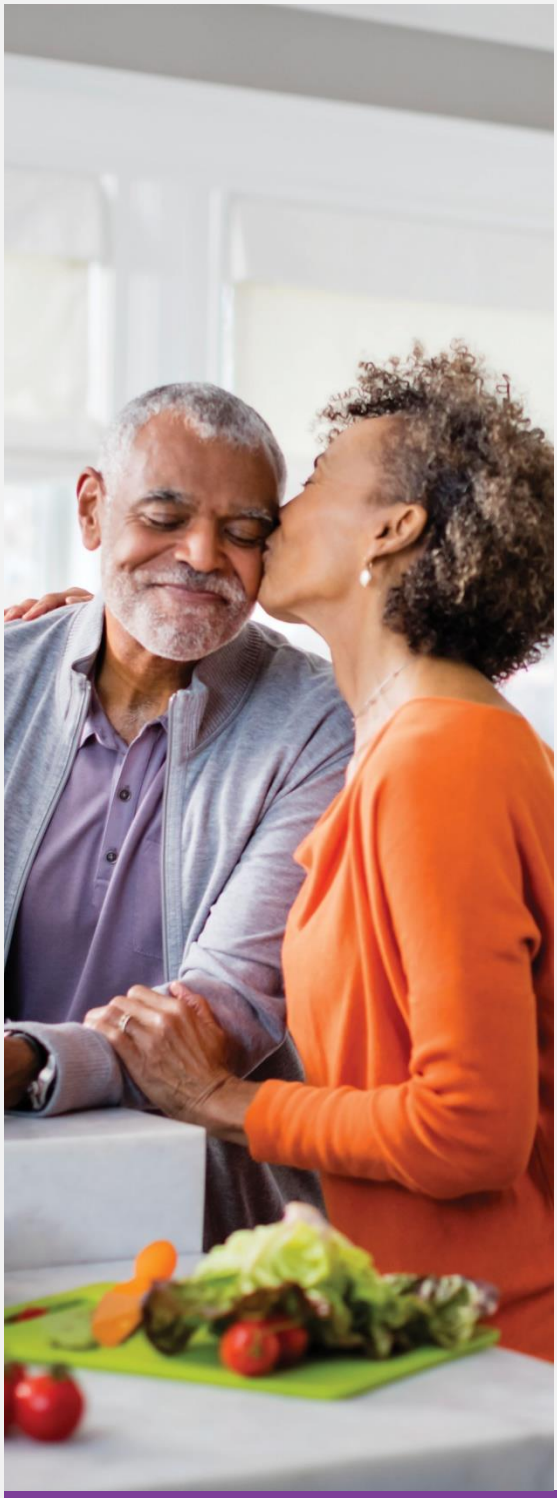

# Important policy updates (including pharmacy)

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment.

We're required to notify you of any change that could affect you either financially or administratively. These changes may not be considered material changes in all states.

Unless otherwise stated, policy changes apply to both Commercial and Medicare lines of business.

## Claim and Code Review Program (CCRP) update

Starting March 1, you may see new claim edits.

This update applies to both our commercial and Medicare members.

Our program evaluates claims against industry coding guidelines such as those from the Centers for Medicare & Medicaid Services (CMS), American Medical Association Current Procedural Terminology (CPT®) coding standards, and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies.*

Beginning March 1, 2026, 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 Spaces > Resources. In the search bar, search for "expanded claim edits."

Except for Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to Availity®. You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

We may request medical records for certain claims, such as high-dollar claims, implant claims, anesthesia claims and bundled services claims, to help confirm coding accuracy.

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Note to Washington State providers: For commercial plans, your effective date for changes described in this article will be communicated to you following regulatory review.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be outlined in this article.

Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

## Changes to our National Precertification List (NPL)

This change applies to both our commercial and Medicare members.

Effective March 1, 2026, we'll require precertification for the following:

- Osteotomy hip (27146 and S2115)

**Submitting precertification requests**

Submit precertification requests at least two weeks in advance and include the actual date of service in the request. To save time, request precertification online through our **provider portal on Availity**.* Doing so is fast, secure and simple.

You can also use your practice's Electronic Medical Record (EMR) system if it's set up for electronic precertification requests. Use our "Search by CPT® code" function on our **Precertification Lists** page to find out if the code requires **precertification**.**

If you need precertification for a specialty drug for a commercial or Medicare member, submit your request through Novologix®, which is available on Availity®.

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Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or

October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

## Changes to commercial drug lists begin on April 1

Find out about drug list changes and how to request drug prior authorizations (PAs).

On April 1, 2026, we'll update our pharmacy drug lists. Changes may affect all drug lists, precertification, step therapy and quantity limit programs.

You'll be able to view the changes as early as February 1, 2026. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

**Ways to request a drug PA**

- Submit your online PA through **CoverMyMeds**.
- For requests for non-specialty drugs, call **1-800-294-5979 (TTY: 711)**. Or fax your **authorization request form (PDF)** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-814-5506 (TTY: 711)** or go to our **Forms for Health Care Professionals** page and scroll down to the Specialty Pharmacy Precertification (commercial) drop-down menu. If the specific form you need isn't there, scroll to the end of the list and use the generic Specialty Medication Precertification request form. Once you fill out the relevant form, fax it to **1-866-249-6155**.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

**More information**

For more information, refer to the **Contact Aetna** page.

## Important pharmacy updates

Read the updates for Medicare, Medicare Part B step therapy and commercial.

**Medicare**

Visit our **Medicare Drug List** page to view the most current Medicare plan formularies (drug lists). We update these formulary documents regularly during the benefits year as we add or update additional coverage each month.

Visit our **Medicare Part B Step Therapy** page to view the most current Preferred Drug Lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. We update these lists regularly throughout the plan year.

**Commercial — notice of changes to prior authorization (PA) requirements**

Visit our **Formularies and Pharmacy Clinical Policy Bulletins** page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs we add monthly
- Clinical policy bulletins with the most current PA requirements for each drug

**Student Health**

Visit **Aetna Student Health** to view the most current Aetna Student Health℠ plan formularies (drug lists). Follow these steps:

1. Select your college or university and click "View your school."
2. Select the "Members" link at the top of the page.
3. Click the "Prescriptions" link under Resources for Members.
4. Scroll down to the Aetna Pharmacy Documents section.

**Aetna federal employee plans**

Visit our **Aetna Federal Plans** website to view the most current formularies (drug lists).

# State-specific updates

Here you'll find state-specific updates on programs, products, services, policies and regulations.

## Updates to official notice addresses for contract termination notification

New addresses are effective immediately.

*This article applies to the following states: Alaska, Idaho and Oregon.*

Over this past year, we've been migrating several of our office-based provider notice addresses to a specific P.O. box as we move to a digital mail system.

If you've been using any of the following old addresses when providing a contract termination notification, please start using the new address effective immediately.

**Alaska address**

Old address: Seattle, 600 University Street
New address: Network Management
P.O. Box 818012 Cleveland, OH 44181-8012

**Idaho address**

Old address: Seattle, 600 University Street
New address: Network Management
P.O. Box 818012 Cleveland, OH 44181-8012

**Oregon address**

Old address: Seattle, 600 University Street
New address: Network Management
P.O. Box 818012 Cleveland, OH 44181-8012

For new addresses for Arizona, California, Colorado, Kansas, Maine, Michigan, Nebraska, Nevada, New Jersey, Texas, Utah, Virginia and Washington, refer to page 9 of the **June 2025 quarterly issue of OLU**.

## Reminder: Affordable Care Act (ACA) and Qualified Health Plan (QHP) health exchange participation update

Effective January 1, 2026, Aetna CVS Health®, Banner|Aetna and Innovation Health will be exiting the Individual and Family plans (IFPs) exchange business.

*This article applies to the following states: Arizona, California, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Missouri, Nevada, New Jersey, North Carolina, Ohio, Texas, Utah and Virginia.*

We greatly value our partnership with you and are committed to supporting you and your patients throughout 2025. Our team will continue to help members maximize their benefits and ensure a smooth transition during this period.

For additional details and answers to common questions, please refer to our FAQs:

- **Aetna CVS Health provider FAQs**
- **Banner|Aetna provider FAQs**
- **Innovation Health provider FAQs**

## Watch for the new Aetna® Medicare Extra Benefits card

Your patients might start showing you this new card.

*This article applies to the following states: Illinois, Kansas, Kentucky, Michigan, Minnesota, Missouri and Ohio.*

Medicare members enrolled in certain plans could have access to our Medical Expense Wallet, which holds a quarterly benefit allowance accessible via the Aetna Medicare Extra Benefits card shown below. You may find members presenting this card at the time of their appointment to cover copays associated with services such as physician visits, lab work, and vision and hearing exams.

If a member asks you about their balance, you can tell them to visit **CVS.com/Aetna** or call CVS Health® at **1-844-428-8147** **(TTY: 711)**, 8 AM to 8 PM local time, 7 days a week.


## Reminder: New pre-approval requirements for inpatient rehabilitation, skilled nursing and home health care

Beginning January 1, 2026, certain post-acute care, skilled nursing, and home health care services will require pre-approval.

*This reminder applies to our Medicare Advantage (MA) plans in the following states: New Jersey, New York, Pennsylvania and West Virginia.*

Refer to the **October issue of OLU** to read the original notification, which covers how to secure authorization requests and other important information.

Effective January 1, 2026, the following services will require pre-approval:

- Inpatient rehabilitation, revenue code 128
- Skilled nursing, levels 1, 2, 3 and 4
- Home health, HCPCS (Healthcare Common Procedure Coding System) codes G0151 to G0153; G0155 to G0162; G0299 to G0300; and G0493 to G0496

For a complete list of procedures that need authorization, visit **EviCore healthcare**.

**Questions**

If you have questions, refer to our **Contact Aetna** page.

## Notice of material amendment/change to contract

*This article applies to the following states: Colorado and Ohio.*

For important information that may affect your payment, compensation or administrative procedures, refer to the Important Policy Updates section of this newsletter.

## Reminder: VCC form required for Aetna® Medicare C-SNP enrollment

The Verification of Chronic Condition (VCC) form continues to be a required step in the C-SNP enrollment process.

*This article applies to the following states: Arizona, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Michigan, Minnesota, Missouri, Nevada, New York, North Carolina, Ohio, Pennsylvania, South Carolina and Texas.*

Our Chronic Special Needs Plans (C-SNPs) help eligible members with diabetes, congestive heart failure (CHF) and/or cardiovascular disorders better manage their conditions and improve overall health.

In 2026, C-SNPs will expand into additional counties across several states. The VCC requirement applies in all counties where C-SNPs are offered, including:

- Currently participating counties in Illinois and Pennsylvania
- Newly added counties in the following states beginning January 2026: Arizona, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Michigan, Minnesota, Missouri, Nevada, New York, North Carolina, Ohio, Pennsylvania, South Carolina and Texas

**C-SNP enrollment is a two-step process**

**Step 1:** Enrollee completes a Medicare Pre-Qualification Assessment Tool (PQAT) form as part of the enrollment application.

Enrollees must complete a PQAT form that includes their qualifying diagnosis and contact information for at least one provider who can verify the member's chronic condition.

**Step 2:** Providers complete the VCC form within the first 30 days of enrollment.

We send the VCC form to the provider (PCP or specialist) listed on the application via fax and/or email based on the contact information the member submitted on the PQAT form. If an email address is provided, the provider will also receive an email with an access code to attest to the member's qualifying condition electronically via their Availity® account.*

If we don't receive the completed VCC form confirming the member's qualifying condition by the end of the second month post enrollment, the member will be involuntarily disenrolled from the C-SNP plan.

**How to access and submit the VCC form**

You can complete and submit the form using one of the following methods:

- Our **provider portal on Availity**. Go to Aetna Payer Spaces > Resources. In the search bar, search for "VCC."
- Our **Forms for Health Care Professionals page.** Select "Chronic Condition Special Needs Plans (C-SNPs): Enrollment Verification" from the drop-down menu.
- Going directly to the **VCC form (PDF)**. You'll find submission instructions at the bottom of the form.

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## Arizona: Changes to our Enhanced Clinical Review program

You'll soon need to get radiation therapy and oncology prior authorizations (PA) from EviCore healthcare.

*This update applies to Aetna® commercial products in Arizona.*

Currently, our Enhanced Clinical Review program requires that you get prior authorization for radiation therapy and oncology procedures with CVS Health Solutions.®

Starting January 1, 2026, you'll need to secure prior authorization from EviCore healthcare.

**About authorization requests**

Before you perform and get paid for services, EviCore board-certified physicians must review authorization requests for medical necessity.

If a date of service is on or after January 1, 2026, and you haven't already requested precertification, contact EviCore to request authorization.

We review radiation therapy services in accordance with nationally recognized clinical and billing guidelines of the American College of Radiation Oncology, American Society of Radiation Oncology, other recognized medical societies and our **Clinical Policy Bulletins (CPBs)**.

For a complete list of procedures that need authorization, please go to our **Precertification Lists** page. To review our Clinical Policy Bulletins, go to our **Clinical Policy Bulletins** page. You can also visit the **EviCore Aetna Resources** page.

**Urgent requests**

If a patient needs services in less than 48 hours due to medically urgent conditions, please tell the representative that the request is for urgent care.

**How to secure an authorization**

You can:

- **Go to EviCore**
- Call **1-888-622-7329** during normal business hours
- Fax a **request form**, which is available online
    - For radiology, cardiology and radiation therapy requests, use fax number **1-800-540-2406**.
    - For sleep requests, use fax number **1-866-999-3510**.
    - For interventional pain requests, use fax number **1-855-774-1319**.

**What you should know**

- We recommend that ordering physicians get authorizations and share the approval numbers with the facility performing the procedure when it's scheduled.
- EviCore will fax the approval decision to the ordering physicians and requested facilities.
- Approvals have authorization numbers and one or more CPT® codes specific to the approved services.*
- If the service you ask for differs from what EviCore approves, the facility must contact EviCore for review and approval before submitting claims.
- If you perform services without approval, we may deny payment. Please don't ask members for payment, as outlined in your agreement with us.
- We'll determine coverage under the applicable policy in accordance with the policy's terms and conditions and with our policies and procedures.

**Questions**

If you have questions, refer to our **Contact Aetna** page. **Visit EviCore** to review criteria and get request forms.

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## Florida: Aetna® expands partnership with iCare Health Solutions for vision services

Check your participation status with iCare Health Solutions before providing services to Aetna Individual Medicare PPO members.

Beginning January 1, 2026, iCare Health Solutions will provide the following vision services to Aetna Individual Medicare PPO members:

- Routine eye exams
- Follow-up diabetic eye exams
- Eyewear
- Eye medical and surgical services

**Confirm your participation status**

Before providing vision services to Aetna Individual Medicare PPO members, call iCare Health Solutions to verify your participation status at **1-855-373-7627**, Monday through Friday, 8 AM to 7 PM ET.

If you'd like a list of participating providers, visit **iCare Health Solutions**. Note that teaching facilities and centers of excellence don't participate with iCare Health Solutions.

**How to submit claims**

Submit claims directly to iCare Health Solutions.

## Georgia: Changes to the Aetna® Chiropractic Network

Beginning January 1, 2026, American Specialty Health (ASH) will no longer manage credentialing, utilization management or claims payment for chiropractic providers and services.

The ASH chiropractic program will end for members in the state of Georgia. Medicare Advantage Supplemental chiropractic benefits for Georgia will remain with ASH.

**Contract changes**

When the ASH program ends, you'll continue to participate in our networks if you start a new direct contract with us. You'll receive a new chiropractic contract directly from us via email. If you don't receive it, **email our Georgia team**.

**Claims payment changes**

For dates of service on or after January 1, 2026, don't submit chiropractic claims to ASH. Instead, submit these types of claims directly to us. There's no change to the filing of Medicare Supplemental claims; they should continue to be billed directly to ASH.

## Maine: Contraception coverage

The Maine Contraception State Mandate says that health plans not restricted by other regulations will cover the following:

- Prescription contraceptives
- Nonprescription oral hormonal contraceptives
- Nonprescription emergency contraceptives

These contraceptives must be approved by the federal Food and Drug Administration (FDA) and prescribed by a health care provider. Patients don't have to pay cost-sharing or out-of-pocket amounts, such as coinsurance or copayments, and the cost of the prescription doesn't get applied to their deductible.

## Massachusetts: Access our pain management resources

We encourage you to regularly review the Clinical Policy Bulletins (CPBs) and related pain management programs. Visit our **Medical Clinical Policy Bulletins** page to access CPBs and pain management protocols.

## Massachusetts: Current coverage information

Verify patient eligibility and consult our **Clinical Policy Bulletins** for the most current coverage information, including that for GLP-1 medications.

# Nevada: Here's how we handle claims

Read about what happens when you submit a claim.

This article serves as your annual notice, in accordance with NRS 687B.730, about how we handle claims.

Nevada law requires that we provide you with a detailed explanation of the process by which we pay claims, including contact information for the department that handles claim disputes.

**Make sure your claim is "clean"**

A clean claim, whether submitted by mail or electronically, must be on a CMS-1500 form (for physicians and other professional providers) or a UB-04 form (for institutional providers) and include all pertinent information and attachments.

You may submit a claim using a different format as long as the format has been adopted by the National Uniform Billing Committee (NUBC) or the National Uniform Claim Committee (NUCC).

**How to submit your claim**

To file electronically, use your office's Practice Management System vendor. (First, determine whether the vendor can send claims to us electronically.) If you don't have a vendor or if that vendor cannot accommodate the request, contact one of our **clearinghouse vendors**.

You can also submit claims on our **provider portal on Availity**.* If you're not currently using it, you'll need to register.

To submit by mail (HMO and PPO products), mail the claim to:

Aetna
P.O. Box 14079
Lexington, KY 40512-4079

**What happens when you file a claim**

Here's how it works:

- If your claim is clean, Nevada law requires us to approve or deny it within 21 days (if submitted electronically) or 30 days (if not submitted electronically).

- If your claim is not clean and we need additional information to decide whether to approve or deny it, we must request the additional information within 20 working days after receipt of the claim.
- Once we have the additional information, we must approve or deny the claim within 21 days (if the additional information was submitted electronically) or 30 days (if not submitted electronically).

**Claim inquiries**

To confirm the date we received your claim or to make other inquiries about claims, you may use your preferred electronic claim status vendor, check Availity®, or visit our **Contact Aetna** page.

**How to dispute a claim**

First, read our **dispute and appeals process FAQs**. If you still need help, read more on our **Disputes and Appeals page**.

**More information**

To find out more about how we work with claims, response times, and reconsiderations and appeals, refer to the Nevada tab on our **State Regulations** page.

To reach the department responsible for reviewing denied claims or to inquire about your claim or claim dispute, visit our **Contact Aetna** page.

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## Pennsylvania Employees Benefit Trust Fund (PEBTF) plan changes

Find out about referrals, checking eligibility and the new ID card.

Effective January 1, 2026, PEBTF will use Aetna® as its exclusive commercial medical carrier for its active and early retiree members. These members will receive a new ID card (shown below) in the middle of December.

**Claim submission**

For dates of service on or after January 1, 2026, submit claims using the new ID card. To confirm eligibility and benefits, continue to use our **provider portal on Availity**.*

**Referrals**

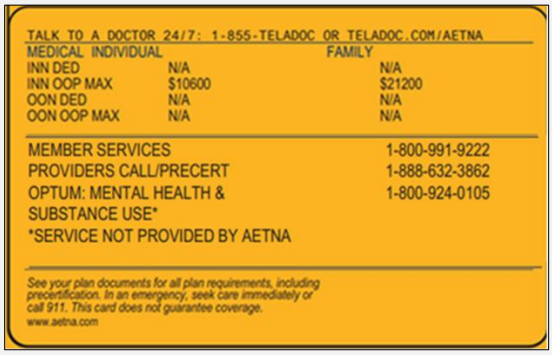
Beginning in January, the PEBTF Custom HMO plan won't require a referral to see a specialist (as denoted on the new ID card). Patients can get care from any PEBTF Custom HMO health care professional in the Commonwealth of Pennsylvania. Optum will continue to administer mental health and substance use benefits.

**Other information**

Medical coverage outside the Commonwealth is limited to urgent/emergent care only.

**Sample ID card**

Here's an example of the new ID card:


**Questions?**

Refer to our **Contact Aetna** page.

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## Rhode Island: Primary care prior authorization (PA) reform

As of October 1, 2025, we've removed PA requirements for services ordered by primary care providers in the normal course of business for our fully insured Rhode Island members. This update was made in accordance with R.I. Gen. Laws §27-18.9-16(a) and the Rhode Island Prior Authorization Reduction and Improvement Pilot Program.

Continue to verify member eligibility and consult our **Clinical Policy Bulletins** for the most current coverage and authorization guidelines.

# Virginia: Electronic overpayments management is coming soon

You may receive overpayment communications electronically.

In accordance with VA Code §38.2-3407.15, if you've opted into electronic communications, you'll receive overpayment communications electronically. Some third-party vendors will continue to send their own overpayment communications.

To meet this requirement, we've launched Overpayments on our **provider portal on Availity**.* You'll be able to use this tool to manage overpayments online. We posted an announcement in Availity® to mark the October 2025 launch of this feature.

With Overpayments on Availity, you can:

- View/download your overpayment notifications
- More easily keep track of overpayment notifications we've sent you from the Overpayments dashboard
- Message directly with our Overpayment Support Team
- Resolve or dispute overpayment notifications
- Get status updates and view case history
- Upload supporting documentation

**How to access the tool**

You can find the Overpayments feature in the Claims & Payments menu in your navigation bar.

You'll need the Claim Status and Claims Overpayment Recovery roles to access Overpayments. If no one in your office has these roles yet, the Availity administrator can assign them.

**More information**

Consult our detailed Overpayments Management on Availity resource guide, which you can find in the Resources section of our Payer Spaces.

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# News for you

You'll find information — new services, tools and reminders — to help your office comply with regulations and administer plans.

## New provider onboarding webinar for providers and their staff

Take our "Doing business with Aetna" webinar to get lots of your questions answered.

New to Aetna®? Or do you simply want to see what's new? Join us in our new provider onboarding webinar — **"**Doing business with Aetna" — to discover tools, processes and resources that'll make your day-to-day tasks with us simple and quick.

We'll show you how to:

- Locate provider manuals, clinical policy bulletins and payment policies
- Access online transactions such as those related to eligibility, benefits, precertifications and claim status/disputes
- Locate Help & Training on Availity*
- Access our online forms
- Navigate to our provider referral directory and Medicare directory
- Update your provider data and much more

**Register today**

The **new provider onboarding webinar** — **"**Doing business with Aetna" — is offered on the second Tuesday and third Wednesday of the month from 1 PM to 2 PM ET.

**Questions?**

Just **email us** with any questions that you may have. We look forward to seeing you in an upcoming session.

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# Cultural competency can help your practice

You can improve your relationship with your patients by taking simple steps, such as directing patients to interpretation services and registering for Continuing Medical Education (CME) courses.

Recognizing that members have diverse views is critical to meeting their needs. The cultural factors that will likely affect your relationships with members include age, gender identity, language, religion, and values, to name a few. It's important to respect and respond to members' distinct values, beliefs, behaviors and needs when caring for them.

**Our commitment**

We're committed to meeting the National Committee for Quality Assurance (NCQA) standards to ensure that we meet members' cultural, ethnic, racial and language needs.

**Culture, race and ethnicity**

To demonstrate our commitment to meeting all NCQA standards and ensuring that member access to care is available and satisfactory, each year we ask members about in-network providers' ability to meet their needs. We do this through the Consumer Assessment of Healthcare Providers and Systems (CAHPS). We use the responses to monitor, track and improve members' experiences.

**Language**

Members with limited English proficiency have access to translation and interpretation services. Members also have access to TTY/TDD services for the hearing impaired.

Your Aetna® patients can access interpreter services by calling the number on the back of their ID card. There's no charge for this interpretation service.

**Practitioner training on cultural competency, humility, diversity and inclusion:**

- Visit our **new clinical educational hub**. It includes free, on demand courses on health equity and related topics.
- The U.S. Department of Health & Human Services, Office of Minority Health, offers free, **continuing education e-learning programs** (Culturally and Linguistically Appropriate Services in Maternal Health Care, Behavioral Health, Oral Health) to help health care professionals provide culturally competent care.
- The American Medical Association **Delivering Care — Health Equity** and the American Academy of Family Physicians **Health Equity CME** websites offer resources and educational opportunities, including CME courses, for additional training on multiple topics, including health equity, diversity and inclusion.
- Visit our **Health Equity page** to find out more about reducing health care disparities.

**Want to learn more?**

Watch our **cultural competency training video**.

## January 2026 provider and behavioral health manual updates

Find out about recent changes.

These updates apply to our commercial, Medicare and Student Health provider communities.

Each year, we update several **provider manuals** to ensure you have access to the most current information.

We've revised your provider manual, including but not limited to the following sections:

- Claims and billing
- Electronic solutions
- Availity® file size limitations*
- Claim disputes and appeals
- Overpayments
- Member programs

In addition to updates in the provider and behavioral health manual, you'll also find changes in the following resources:

- The at-a-glance reference guide
- The state supplement manual
- The network participation criteria manual

These updates aren't considered material changes. If you have any questions or need further clarification, contact your Aetna® representative.

*Availity® is available only to providers in the U.S. and its territories.

## Non-discrimination requirements: An overview of the Affordable Care Act (ACA), Section 1557

Your contract with us requires you to follow all state and federal laws.

**Section 1557 of the ACA** under Title 42, Part 18116, prohibits discrimination in health care programs and activities based on race, color, national origin, age, disability or sex. As our partners providing health care programs and activities, you should review all the ways you can comply with the necessary provisions. Here are a few:

**Limited English Proficiency (LEP) language assistance services**

Provide no-cost language assistance services to ensure effective access to health care for those with limited English proficiency.

**Communicating with those who have disabilities**

Communication with those who have disabilities must be as effective as communication with others.

**Reasonable modifications**

You have to consider reasonable ways of modifying policies or procedures so that people with disabilities have the same access and opportunities as other people.

**Non-discrimination in health insurance coverage or other health-related coverage**

In providing or administering health insurance coverage, you can't discriminate based on race, color, national origin, age, disability or sex. If you have a legitimate, non-discriminatory reason, you can deny or limit coverage or decide that the health service fails to meet coverage requirements, such as medical necessity.

**Patient-care-decision tools, such as AI tools or flowcharts**

You can't discriminate on the basis of race, color, national origin, sex, age or disability through the use of these automated or non-automated tools for clinical decision-making.

**Grievances**

You have to give people a way to file a grievance if they believe we haven't met our obligations under Section 1157. **Email our Civil Rights Coordinator** for more information.

## Proper coding for breast cancer screenings

Accurate coding helps your patients get the coverage they are entitled to receive.

Effective January 1, 2026, the Health Resources and Services Administration (HRSA) will implement updates to breast cancer screening guidelines.

The HRSA recommends that women get annual mammograms starting between the age of 40 and 50 and that they continue to do so through at least age 74. Supplementary imaging and testing, such as magnetic resonance imaging (MRI), ultrasounds, and pathology evaluations, are considered to be preventive.

Regularly review resources from the United States Preventive Services Task Force (USPSTF) and HRSA to ensure that patients aren't charged cost-sharing amounts for recommended preventive items and services.

**The importance of proper coding**

Proper claim billing is essential for these benefits to be paid as preventive. Additional mammograms (including 3D mammograms), breast ultrasounds, MRIs, and core needle biopsies and the accompanying pathology services (when performed in conjunction with routine preventive breast cancer screenings) are considered preventive care.

Claims for these services should be submitted with a preventive diagnosis code. The administrative departments referred to above consider the following to be reliable coding resources:

- Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS Level II)
- The required CPT® codes of the American Medical Association, the American Hospital Association and the Women's Preventive Services Initiative.*

*CPT® is a registered trademark of the American Medical Association. 2024 All rights reserved.

## Ordering somatic oncology molecular diagnostic (MDx) tests can be easier with Spesana

Spesana is a Health Insurance Portability and Accountability Act (HIPAA)-compliant, cloud-based platform designed to support MDx ordering, tracking and results retrieval.

You can use the **Spesana** MDx ordering platform to:

- Choose from a list of molecular diagnostic laboratories
- Track test status and turnaround times
- Get structured and timely test results integrated into your workflow

In the future, as other payers adopt the platform, you'll be able to filter by insurance carrier to find your patients' in-network labs. For now, you can filter to find Aetna® preferred labs for all commercial health plans (not Medicare or Medicaid at this time).

**How Spesana could help you**

Spesana enables your team to focus more on clinical care and less on administrative tasks. By partnering with insurance carriers like us, Spesana is making it easier for you to have

preferred lab choices at your fingertips. And it can share data with your existing electronic health record.

**How to get started**

You can enroll with **Spesana** at no cost. To enroll or learn more, you can **email Spesana Provider Support** or call **1-888-958-2298** or **1-901-634-7677**.

## We've updated our guidance on how to use electronic claim payment tools

Understanding your electronic remittance advice (ERA) and electronic explanation of benefits (eEOB) will help you review claim payments.

We've revised our **Electronic Payment and Remittance page** so you can review claim payments and get paid faster.

**ERA and eEOB guidance**

ERA provides claim payment explanation in files that comply with the Health Insurance Portability and Accountability Act (HIPAA). You can enroll in ERA by going to **Payer Enrollment Services**. eEOBs are electronic versions of our EOB statements and can be accessed from the Remittance Viewer or the Claim Status Inquiry transaction on our **provider portal on Availity**.*

The eEOB has more details, such as remark messages explaining how a claim was processed or if we need more information to process a claim. Commercial pended claims aren't included in ERA. You'll need to review the eEOB for more details on why the claim is pending.

You don't need to enroll in ERA to get eEOBs.

**What you need to know**

- For more detailed information, you can download copies of your eEOBs on Availity®.
- For pended claims, you can review your eEOB for the remark details or requested information.
- ERAs provide claim payment explanation whereas eEOBs provide claim processing information.

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## Infertility coverage prior authorization (PA) requests now include associated drugs

These changes don't apply to Medicare or Medicaid plans.

We've simplified the process for certain female infertility coverage requests, such as those for in vitro fertilization (IVF). Previously, you had to request one PA for certain infertility procedures and a separate PA for the drugs associated with that procedure covered under the Aetna® pharmacy plan.

Just submit a PA request for the procedure under the medical plan. If we approve, your approval covers the procedures and the associated formulary medications covered under the Aetna pharmacy benefit. Then, simply send a prescription to the specialty pharmacy for the preferred drug on the member's formulary. We'll handle the rest.

We hope that eliminating the second PA saves you time. We encourage you to submit your initial PA request using our **provider portal on Availity** or your preferred electronic vendor or clearinghouse.* Submitting your requests electronically will save you even more time.

For further coverage details, consult our **infertility Clinical Policy Bulletin (CPB)**.

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## Tips for working with Aetna® clinical teams

Read about how to use Availity® for PAs, our forms library and how to send a fax.*

Use our **provider portal on Availity** to submit your PA requests. It's faster than calling, and you can check status and upload clinicals through the site. Submitting is an easy five-step process:

1. Whether you're an individual provider or facility, select your role from the Requesting Provider Type and enter the requested information.
2. Provide the service(s) the patient needs.
3. We'll tell you whether PA is required. If PA isn't required there's nothing else you need to do.
4. If PA is required, upload clinicals, so they'll be available to our clinical teams. You can also upload clinicals after your initial PA request. Just pin your request to your Availity Authorization/Referral Dashboard, select it when you're ready to upload clinicals and follow the steps.
5. Confirm your inputted information and submit your request. We'll return a decision right away.

If you're already registered for Availity, we encourage you to use it. The site has many tools and training materials you can use to help manage your patients and your interactions with us.

**Get the forms you need from our library**

We might need to ask you for additional PA information. If so, choose the **applicable form** (in the drop-down menu, select the most accurate form). Complete it online, save it to your computer and upload it during step 4 in Availity.

Make sure to complete all questions on the form, since missing information can delay our review. For example, the Spinal Surgery Precertification Information Request form often has missing information in the following fields:

- Instrumentation — we need information for both the brand and manufacturer
- Nicotine/cotinine status
- Physical therapy (PT) notes when the patient had PT in the last 12 months

As we work to ensure our compliance with the Centers for Medicare & Medicaid Services (CMS) Final Rule in 2026, we'll have less time to process your requests. Missing or incomplete information on the forms may have adverse effects.

**If you must send a fax, verify the information before sending**

While our preference is to receive clinicals via Availity, we understand that some offices and facilities still prefer to send and receive faxes. Remember to include the authorization number (if a patient has more than one, use the most recent one) with the patient's demographic information (name, Aetna member ID number and date of birth), so we can match the fax to the correct record.

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## Send clinical information for NICU cases using the baby's information

Submitting clinical information with the incorrect authorization can delay processing and response time.

When sending us clinical information for a baby in the neonatal intensive care unit (NICU), use the baby's authorization, not the mother's. We manage authorizations for mothers and babies separately.

If the baby doesn't yet have an existing authorization or if the plan requires the baby to be added to the plan first, ask the member to contact their human resources department or Aetna Member Services. Once enrollment is complete, we'll provide an authorization up to 14 days after discharge; otherwise, you should submit a claim for review.

**Submit clinical information using Availity®**

You can submit clinical information via our **provider portal on Availity**.* This method helps us process the records faster and serve you more efficiently.

Here's how:

- If you've already pinned the request for the baby on your Authorization/Referral dashboard, select the event in your dashboard, then choose the Add Attachments button and follow the steps.
- If you don't have the request in your dashboard, complete an Authorization Inquiry transaction. Once you receive the response, select the Add Attachments button and follow the steps. Choose Pin to Dashboard to pin the request to the top of your dashboard for easier access.

If you're not registered for Availity, you can use the Get Started link in the upper-right corner to register.

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## Coming soon: Important updates to our medical record documentation requirements

In 2026, we'll clarify and consolidate changes to our medical documentation requirements.

**Notable changes**

Changes include:

- Removing the documentation requirement of some member demographic data
- Clarifying required documentation versus "best practice" documentation

**Why did the requirements change?**

We've established medical record criteria, which provides guidelines for organization, documentation and communication. As participating practitioners, you agree to maintain medical records in accordance with customary medical practice, applicable laws and accreditation standards.

We regularly perform medical record documentation audits per state regulatory mandates to assess the quality of medical record keeping practices. A performance goal of 85% must be met.

Be on the lookout for these changes coming to our provider manual in January 2026.

## How to contact us about utilization management (UM) issues

Staff members, including medical directors, are available 24 hours a day to answer your UM questions.

There are various ways to contact us, both during and outside of business hours. Free language assistance is available through our bilingual staff or interpreters.

**During business hours**

During our business hours (8 AM to 5 PM, Monday through Friday), contact us by calling the toll-free precertification number on the member's ID card. If there's only a Members Services number on the card, you'll be directed to the precertification unit through a phone prompt or representative.

**After business hours**

You can reach us in various ways.

- Visit our **Contact Aetna** page.
- If you have a question about a member covered by a commercial plan, call our Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** and choose precertification.
- If you have a question about a member covered by a Medicare plan, call our Provider Contact Center at **1-800-624-0756 (TTY: 711)** and choose precertification.
- Call the patient management and precertification staff using the Member Services number on the member's ID card.

# Behavioral health

Stay informed about behavioral health coverage updates so you can deliver the best possible treatment to your patients.

## We're changing how we review outpatient behavioral health services

Effective January 1, 2026, we're removing concurrent review for in-network and out-of-network outpatient behavioral health services subject to precertification.

**What services currently require concurrent review?**

We perform concurrent review on all inpatient admissions for which precertification is required. We also require it for the following outpatient behavioral health services:

- Applied Behavioral Analysis (ABA)
- Transcranial Magnetic Stimulation (TMS)
- Partial Hospitalization (PHP)

**What's changing?**

We'll no longer conduct concurrent review for the in-network and out-of-network outpatient services listed below. If care is needed beyond the initial precertification, submit a new precertification request. We'll review the new request for medical necessity and appropriateness. Inpatient services aren't impacted by this change.

**What services are affected?**

- ABA: 97151–97158, 0362T, 0373T
- TMS: 90867–90869
- PHP

**Why is this change happening?**

We're updating our utilization review processes to be consistent across mental health/substance use disorder services and medical/surgical services.

# Applied Behavioral Analysis (ABA) medical necessity guide updates

We'll release a revised **ABA medical necessity guide** on January 1, 2026. We'll evaluate ABA precertification requests using the revised criteria. Please review the updated guide upon release to ensure familiarity with the criteria.

**Medical necessity criteria for applied behavior analysis**

All the following criteria (shown here as they'll be published in January) must be met:

1. There is a DSM-V diagnosis of Autism Spectrum Disorder (ICD-10: F84.0; F84.3 – F84.9) obtained by an appropriate provider.
2. Services must be provided directly or billed by the appropriately licensed provider.
3. There is demonstration of functional impairment on a standardized scale of functioning in the past 12 months. For instance, the Vineland Adaptive Behavior Scales 3 (VABS-3), the Adaptive Behavior Assessment Scale (ABAS), VB-MAPP or ABLLS. The impairment must be at least one standard deviation below the population mean OR represent a significant risk of harm to self or others.
4. The treatment plan documents have specific identified target behaviors related to the condition, that are clearly defined: frequency, rate, symptom intensity or duration, or other objective measures of baseline levels are recorded, and quantifiable criteria for progress are established. The plan describes behavioral intervention techniques appropriate to the target behavior, reinforcers selected, and strategies for generalization of learned skills are specified. And there is documentation of planning for transition through the continuum of interventions, services and settings, as well as titration and discharge criteria. The treatment plan documents a gradual tapering of higher intensities of intervention and a shifting to supports from other sources (school, as an example) as progress occurs.
5. In order to support clinical appropriateness for ABA services, (1) In instances where the frequency of the target behavior has improved over the course of treatment, documentation is included OR (2) If there has NOT been improvement, there is documentation of modification of the treatment, additional assessments that have been conducted, and/or there has been appropriate consultations from other staff or experts.
6. The level of impairment justifies the number of hours requested.

## The behavioral health section of our provider manual keeps you informed

Learn more about clinical management and delivery, medical record documentation requirements and our behavioral health case management program.

Visit us online to view a copy of the **Office Manual for Health Care Professionals (PDF)**. If you don't have Internet access, go to our **Contact Aetna** page to request a paper copy.

**What's in the manual**

The manual contains information on the following:

- Our behavioral health guiding principles
- Behavioral health medical record documentation requirements
- Our behavioral health case management program and how to refer your patients
- Member rights and responsibilities
- Telehealth services
- Clinical management and delivery, including coordination of care
- Our behavioral health quality program

**More information**

If you have general questions, refer to our **Contact Aetna** page. If you have questions related to the information in this article, you can **email the Behavioral Health Quality Management team**.

## We value your responses to our annual practitioner surveys

Your participation in the 2026 survey will help us help you (and our members).

We know that it's important to include you in our quality programs because you're the ones who improve member outcomes.

**About our surveys**

Our yearly surveys help us:

- Monitor your experience with us
- Learn about our members' access to services
- Learn about your efforts to coordinate our members' care with other practitioners

We review survey results and data from complaints, appeals and out-of-network claims to better understand what's happening within our practitioner network and our membership.

We use this information to improve our services and clinical quality.

**Not receiving the surveys?**

The surveys are sent via email to a random selection of practitioners. Please **update your contact information** so that we're sure to get feedback from as many of you as possible over time.

**Questions?**

If you have any questions about this information, you can **email the Behavioral Health Quality Management team**.


Get Medicare-related information, reminders and guidelines.

## Complete your required Medicare compliance training and attest by December 31, 2025

In spring of this year, participating providers received a training and attestation notice via their compliance email address. If no email address was available, a postcard reminder was mailed, requesting completion by October 31, 2025.

All providers in our Medicare Advantage (MA) plans must meet Centers for Medicare & Medicaid Services (CMS) compliance requirements for first-tier, downstream, and related entities (FDR) as outlined in the training materials below.

To learn more about our MA plans, including Special Needs Plans (SNPs), view our **Medicare Advantage quick reference guide (PDF)**.

**How to submit your attestation**

If you didn't receive a notice or haven't completed your required training(s), visit the **Medicare compliance and attestation** page to review the materials and submit your attestation by December 31, 2025, to remain compliant. Note: Extensions beyond this date will not be granted.

**Training materials**

- **FDR Medicare compliance guide (PDF)**
- **SNPs Model of Care (MOC) provider training (PDF)**
- **Provider and delegate frequently asked questions document (PDF)**

**Attestations based on contracted plans**

Providers:

- MA/MMP: **Complete MA and/or MMP attestation (PDF)**
- MA/SNP: **Complete MA and SNP attestation (PDF)**

Delegates:

- MA/MMP: **Complete MA/MMP attestation for first-tier entities (PDF)**
- MA/SNP: **Complete MA and/or SNP attestation for first-tier entities (PDF)**

**Where to get more information**

If you have questions, choose from the above links or review the quarterly **First Tier, Downstream and Related Entities (FDR) compliance newsletters**.

## VBID hospice model deadline for Notice of Election (NOE) and claim submissions

You must submit NOE and claim submissions for final payment by December 31, 2025.

The Value-Based Insurance Design (VBID) model hospice benefit component concluded at the end of 2024 in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. As stated in prior technical and operational guidance, if you're a hospice provider, you have 12 months from the date of service to file your claims.

Reminder: You must submit all NOEs and claims to Medicare Administrative Contractors (MACs) for final payment by December 31, 2025, for the VBID model hospice benefit component (January 1, 2021 to December 31, 2024). NOEs or claims submitted after December 31, 2025, won't be considered for capitated payments, including the final capitated payment disbursement.

# EyeMed will soon be the Routine Vision Network for Aetna® Medicare Advantage (MA) Individual plan members

Find out how to join the EyeMed network.

*This article does not apply to Florida, select integrated DSNPs and Aetna Group MA plan members.*

Starting January 1, 2026, Aetna MA Individual plan members must see an EyeMed provider for their routine vision benefits (exams and prescription eyewear) for those benefits to be considered in-network.

**Always check eligibility**

Some members have plans that provide only in-network benefits, while others have plans that provide both in- and out-of-network vision and eyewear coverage.

Remember to verify benefits and eligibility via Availity® or your preferred vendor or clearinghouse.*

**HMOs and PPOs**

Aetna MA Individual plan members (HMO/PPO) have access to the Aetna MA contracted network for Medicare-covered (medical/diagnostic) eye care services. Providers not contracted with EyeMed will only be reimbursed up to $50 for any routine (non-Medicare covered) eye exam services rendered for PPO members.

Consult the chart below for 2026 routine eye exam and eyewear benefits (non-Medicare covered).

| Plan type | EyeMed provider | Non-EyeMed provider |
|---|---|---|
| **HMO plan members** | $0 copay for one non-Medicare covered routine eye exam.**<br>$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum. | Not covered |

| | | |
|---|---|---|
| **PPO plan members** | $0 copay for one non-Medicare covered routine eye exam.**<br>$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum. | $0 copay for one non-Medicare covered routine eye exam up to $50.** Members are responsible for any billed amount over $50.<br>$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum. |

**Verify whether you are an EyeMed provider**

To verify, you can visit our **Vision Benefit page**. If you'd like to become an EyeMed provider, fill out this **EyeMed provider form**. Be sure to check the "Join EyeMed as New Provider" box.

*Availity® is available only to providers in the U.S. and its territories.

**If members receive additional services during the routine eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, they may also be responsible for the cost for the additional services received.

## Aetna® Individual Medicare Advantage (MA) 2026 plan expansion

You might be a participating provider for the new counties.

We're expanding our Individual MA plans to **17 new counties (PDF)** for 2026. Depending on your contract, you may be listed as a participating provider in our MA networks.

**2026 Annual Enrollment Period (AEP)**

The Medicare AEP began October 15, 2025, and ends December 7, 2025. We believe that Medicare beneficiaries will be interested in our plans because of our healthy Star Ratings. For 2026, our overall enrollment-weighted rating is 4.19 out of 5 stars (measurement period FY 2024 and early 2025). These ratings reflect the care you give to your patients.

**More about our MA products**

- View our **Aetna Medicare Advantage plans quick reference guide (PDF)**.
- View the **At a glance reference guide (PDF)**.
- Verify patient eligibility on our **provider portal on Availity**.*

**How to get contracted for MA plans**

If you're not contracted for our MA plans, visit our **How to Join Our Network page**.

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