December 2026

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

Availity enhancement: real-time appeal status updates

You asked for better visibility into the status of appeals and reconsiderations, and we listened. As of October 17, 2026, Availity® began providing real-time status information for appeals and disputes submitted through the portal — making it easier to track your cases without contacting us for an update.

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.

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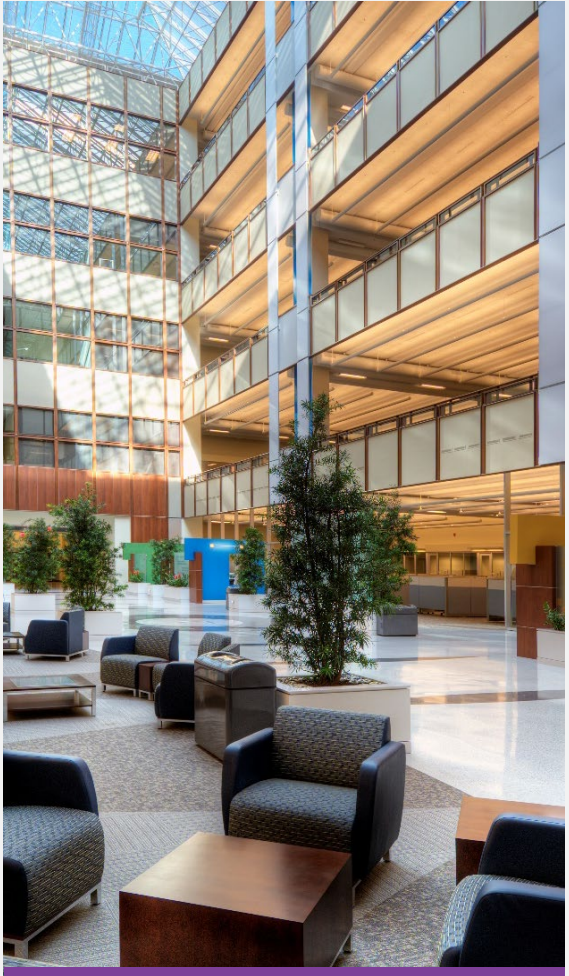

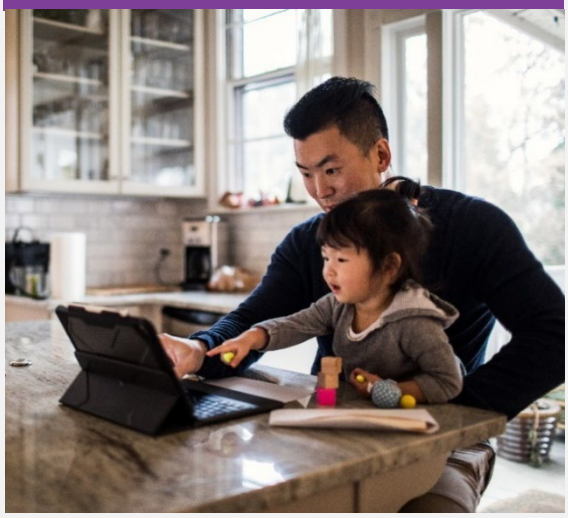

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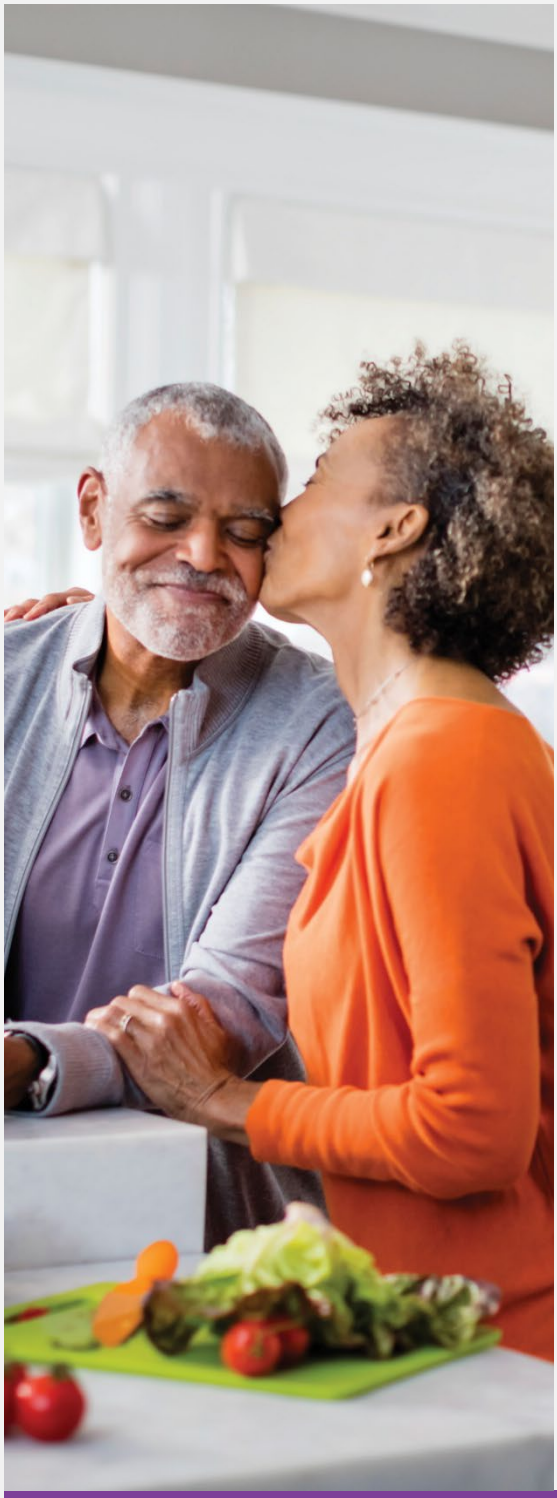



Important policy updates (including pharmacy)

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 our commercial, Medicare and Student Health 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, 2027, 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 as 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.

Upcoming changes to maternity care coding and reimbursement

This update applies to commercial and Medicare members.

Effective January 1, 2027, the American Medical Association (AMA), in collaboration with the American College of Obstetricians and Gynecologists (ACOG) and other specialty organizations, approved a significant restructuring of maternity care coding. These changes will move the industry away from the global maternity billing model and toward a more detailed, service-based coding framework.

What's changing?

Beginning January 1, 2027, global maternity codes will be retired and replaced with a service-level coding structure.

Under the new CPT® framework, maternity care will be reported across four distinct phases:*

- Antepartum (prenatal) care
- Labor management
- Delivery care
- Postpartum care

This change is intended to better reflect how maternity care is delivered today, including team-based and individualized care models.

What you should know

The AMA's CPT Editorial Panel approved:

- Deletion of 17 legacy maternity codes
- Addition of 12 new maternity care codes
- Revision of 6 existing codes

The overall coding framework is final, but implementation details, such as those related to operations and claims processing, are still to come.

Preventive and nonroutine prenatal and postpartum office visits

Routine prenatal and postpartum office evaluation and management (E/M) visits are considered preventive services and have no member cost share.

For these routine preventive visits:

- Submit the applicable E/M code with modifier TH. Modifier TH alone doesn't determine whether the service is considered preventive.
- Report the appropriate pregnancy diagnosis code(s). The diagnosis code associated with the E/M service helps distinguish preventive visits from visits for nonroutine care.

Nonroutine prenatal and postpartum E/M office visits should be submitted with modifier TH and are subject to applicable member cost share.

Review the updated Routine Preventive Care Benefit Guidance statement on our **provider portal on Availity** for additional information.**

Billing prenatal visits during the transition to 2027

For patients expected to deliver in 2027, preventive prenatal visits on or after September 1, 2026, should be billed with the applicable E/M code, modifier TH and pregnancy diagnosis code(s) when three or fewer visits occur before January 1, 2027. Once four prenatal visits have occurred in 2026, billing should follow the current antepartum coding guidelines.

Office visits for medical conditions or complications during the prenatal or postpartum period should be documented and billed based on the medical reason for the encounter.

More information

To support you during this transition, we've created a Maternity Coding Transition Resource on our **provider portal on Availity**. We encourage you to review this resource regularly for the most current information.

Consult these AMA resources to help you understand upcoming changes:

- **CPT 2027 Maternity Care Services Code Changes**
- **A Coding Primer: Previewing the CPT 2027 Restructure for Maternity Care Services Codes**
- **RVS Update Committee (RUC)**

Stay tuned for future communications as additional coding, valuation, reimbursement and fee schedule information become available.

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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 as outlined in this article.

Changes to commercial drug lists

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

On April 1, 2027, we'll update our pharmacy drug lists. These changes may include things like:

- Adding or removing specialty, brand-name and generic drugs
- Changing preferred or non-preferred drugs
- Changing PA, quantity limits, and step therapy requirements

You'll be able to view the changes as early as February 1, 2027. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug PA

- Submit your 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, submit precertification requests online at least two weeks in advance. You can submit specialty drugs with

Novologix® through our **provider portal on Availity** or you can call **1-866-814-5506 (TTY: 711)**.*

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.

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Important pharmacy updates

Read the updates for Medicare Part D, Medicare Part B 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 drug utilization management (UM)** page to view the most current Part B drug UM information. This includes medical necessity criteria, step therapy criteria, and Preferred Drug Lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. We update these materials 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.

Reminder: You can now verify chronic conditions by phone

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.

In the **September issue of OLU** (page 12), we told you about how you can now verify your patients’ chronic conditions by phone. This option allows you to verify a chronic condition for one or multiple patients during a single call, without needing to submit a paper form. To get started, have the patient's name, date of birth, and your NPI or TIN available, then call **1-800-624-0756** **(TTY: 711)** and follow the automated prompts.

Other ways to verify

You can also continue to verify chronic conditions through our other secure self-service options, including email and our **provider portal on Availity.*** For complete instructions, frequently asked questions, and available verification methods, visit our **Medicare Resources** page.

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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.

Medical records audit to come in 2027

Prepare your office in case it's randomly chosen.

This article applies to the following states: Florida and Pennsylvania.

In March 2027, the National Committee for Quality Assurance (NCQA) will audit medical records to comply with Florida and Pennsylvania state regulatory requirements.

What you need to know

Your contract with us requires your participation in quality improvement activities, which includes supplying copies of medical records. If you're chosen for the audit, you should send all of the following information for the time frame of January 2026 through February 2027:

- Face sheet (demographics) or member snapshot
- Signed office visit notes, to include:
    - History and physical
    - Past medical history and diagnosis
    - Problem list (medical and/or behavioral)
    - Diagnosis/reason for visit
    - Lists of allergies and adverse reactions
    - Prescribed medications, including dosages and initial or refill dates
- Treatment plan
- Lab, X-ray or other diagnostic studies ordered with notation of provider review of results
- Documentation of communication with referrals to specialists

What to do next

Fax or email records within 14 days of the request to the specific auditor shown in the letter. If your practice normally uses a copy service to send medical records, we ask that you don't use it for this request so that we're sure to get the records in time.

Thank you for your help in ensuring consistent, accurate and complete documentation of patient medical records, which supports high-quality care.

Arizona: Medicare Prime and Medicare chronic care expansion to Pima County

If you're a participating provider, you've already been notified of the expansion.

Effective January 1, 2027, we'll expand our Aetna® Medicare Prime Health Maintenance Organization (HMO) and Aetna Medicare Chronic Condition Special Needs Plan (HMO C-SNP) service area to include Pima County. Members enrolled in a Medicare Prime HMO or Medicare HMO C-SNP plan can be identified by the plan name on their member ID card.

If you're a participating provider, you've been notified of this expansion and are encouraged to familiarize yourself with the updated service area. As always, you should review member ID cards at the time of service to verify plan enrollment and benefits.

Florida: Upcoming changes to the Aetna® Medicare Advantage home health program (Carelon)

You'll be required to follow Medicare guidelines related to home health care billing.

Effective January 1, 2027, Carelon will no longer manage the Aetna Medicare network for home health care services in the state of Florida.

What to know about this change

If your organization already has a direct contract on file with us, you'll continue to participate in our network. You'll no longer need to submit Aetna Medicare claims to Carelon for payment. Starting January 1, 2027, submit these claims directly to us.

If your organization doesn't have a direct contract on file with us, you'll need to **submit a request** to our National Ancillary Team.

For service dates beginning January 1, 2027, you'll be responsible for billing the appropriate Notice of Admission (NOA) to us.

Change in precertification/prior authorization (PA) process

Effective January 1, 2027, PA requests will no longer be reviewed by Carelon. PA will continue to be required directly through us.

You can submit PA requests through our **provider portal on Availity**.*

You can visit **Aetna.com** to learn more about the precertification process. If you have any questions about submitting a request, you can call us at **1-800-624-0756 (TTY: 711)**.

We're here to help

Thank you for being part of our network. If you have questions, contact Aetna Medicare at **1-855-335-1407**, and choose option 4 for providers.

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

Illinois: Reimbursement rates for behavioral health providers

Beginning January 1, 2027, your reimbursement rate for mental health and substance use disorder services may differ from your contracted rate for Aetna® members covered by applicable health plans that are amended, delivered, issued or renewed on or after January 1, 2027, in accordance with **Illinois HB 1085**, 215 ILCS 5/370c.4.

Illinois: Use the Uniform Electronic Provider Directory Information form to update our directories

Find out how to fill it out and send it to us.

About the form

Beginning July 1, 2026, onboarding, current and terminating participating providers are required to use this form to supply issuers with accurate information for its provider directories.

The form consists of:

- An introduction page
- Four fillable sections (Provider Roster, Facility Location, Medical Group Location, and Independent Provider
- Three reference sections (Practice Limitation, Taxonomy — Individuals, and Taxonomy — Non-Individuals

Where to find the form

You can find the form, or "Uniform Directory template," on our **Insurance Regulations by State** page. Select "Illinois" and scroll to the link at the bottom.

How to use the form

Follow these steps to complete and send the form:

1. Identify the sections that apply to you. Within those sections, look for the word "Required" and "If Applicable" in the grey fields in the middle column. As needed, click on the fields to begin typing.
2. Download the form by right-clicking and choosing "save as" or by choosing the download icon in the upper-right corner.
3. Email the form to **pdsdallas@aetna.com**.

Issuers are required to accept a completed form with required information and use it to update their directories.

Update requirements

Provider directories must be verified at a minimum every 90 days; you're required to respond to verification requests and to notify issuers of directory changes within 10 business days. You don't need to complete every field within the form each time you verify and resubmit your demographic information so long as you can attest that your existing data remains accurate except for any of the fields updated on the form you submit.

By law, effective July 1, 2026, carriers are no longer able to accept paper or fax submissions of provider directory information.

Louisiana: Dental services for cancer patients

Certain dental services must be covered for plan enrollees who have been diagnosed with cancer.

Effective January 1, 2027, a new Louisiana law states that health insurance carriers must cover, when medically necessary, certain dental services for plan enrollees who have been diagnosed with cancer.

The law requires coverage for evaluation, imaging, clinical examination and dental extractions that are medically necessary to reduce the risk of infection, eliminate infection, or treat tooth loss or decay, as part of a pre-cancer treatment screening for an insured member who has been diagnosed with cancer. The dental services must be covered when performed as part of a pre-treatment medical clearance protocol for insured members scheduled to undergo cancer treatment.

This law applies only to fully insured plan sponsors. Oral care providers, including dentists and oral surgeons, should submit claims as they normally do and include a cancer diagnosis.

Questions?

If you need assistance with processing your claim, please contact the Aetna Oral Surgery

Unit at **1-800-531-7895 (TTY: 711)**.

North Carolina: Prepare for the North Carolina State Health Plan's new 2027 tiered network

Participating providers will remain in network.

Beginning January 1, 2027, the North Carolina State Health Plan (Plan) will introduce a new three-tier provider network. While participating providers will be designated as Preferred, Access or Non-Preferred, all participating providers will remain in-network. Please note that Non-Preferred doesn't mean out-of-network. Member cost sharing may vary based on the provider or facility tier selected. We'll continue serving as the Plan's third-party administrator through December 31, 2027.

What you should know

As the 2027 benefit year approaches, you may receive questions from Plan members about provider and facility tiers, how to identify a provider's tier, and how tier selection may affect out-of-pocket costs.

The Plan determines provider tier assignments. You can check your tier designation using the **provider search tool**. Preferred and Access providers will display the appropriate badge in search results, while Non-Preferred providers won't display a badge.

Learn more

To prepare for the 2027 transition, review the provider information guide, frequently asked questions (FAQs) and resources available on the **North Carolina State Health Plan provider website**. Be sure to check these resources regularly for updates, information about your tier designation and tools to help answer member questions about the new network structure.

Utah: Artificial Intelligence (AI) in Utilization Management (UM)

We may use AI to help review and process claims, including auto-approving claims that satisfy established UM criteria, and to support operational and service improvements. We never use AI to make adverse determinations based on medical necessity. Only licensed health care professionals issue medical necessity denials.

Utah: Keep your provider directory information updated

Please notify us of any directory changes, as required by **Utah Statute 31A-22-664**, including but not limited to name, contact information, provider type, specialty, services provided, accreditation status, network participation information, and whether you are accepting new patients. You can update this information through the designated provider data maintenance channels.

If you or a colleague shouldn't be listed in the directory, include the reason (covering only, reads tests, hospital-based, etc.) in your submission or attestation.

Thank you for your help. Timely updates support continuity of care for members.

Washington: New Chronic Condition Special Needs Plan (C-SNP)

Beginning January 1, 2027, we're excited to introduce Aetna Medicare Chronic Care (Health Maintenance Organization (HMO) (H3748-020), a new C-SNP available in King, Kitsap, Pierce, Snohomish and Thurston counties in Washington.

You can identify enrolled members by the H3748-020 contract number shown on the member ID card. To help ensure eligible members receive the specialized support and benefits available through this plan, be sure to review the "**Verify Your Patient's Chronic Condition**" article for important guidance on supporting these members and validating eligibility.



News for you

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

January 2027 provider and behavioral health manual updates

Find out about recent changes.

These updates will be available beginning January 1, 2027 and 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
- Aetna® Medicare Advantage plans
- Provider performance programs
- Aetna Behavioral Health
- Member programs and resources

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® enhancement: real-time appeal status updates

Track appeals and disputes in real time through Availity — without contacting Aetna® for an update.

You asked for better visibility into the status of appeals and reconsiderations, and we listened. As of October 17, 2026, Availity began providing real-time status information for appeals and disputes submitted through the portal — making it easier to track your cases without contacting us for an update.

What changed?

As part of a system enhancement, you're now able to access real-time appeal and dispute status information for all appeals and disputes submitted through our **provider portal on Availity**.*

This enhancement resolves a previous issue that limited appeal status visibility and provides a more seamless self-service experience when tracking submitted appeals and disputes.

What this means

You can:

- View the current status of submitted appeals and disputes in real time.

- Access status information directly through Availity without needing to contact Aetna Better Health for updates.
- Monitor appeals and disputes more efficiently through enhanced self-service functionality.

The Appeals Dashboard can be accessed through the Claims & Payments page. This update only affects the visibility of appeal and dispute status information within Availity.

What didn't change

- The appeal and dispute submission process
- Existing appeal and dispute requirements, timelines and workflows

Thank you for your continued partnership.

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

A new Availity® feature helps reduce prior authorization data entry

Member and service details entered in Availity will now transfer to EviCore healthcare when EviCore manages the service.

What changed

As of October 23, 2026, when Availity determines that EviCore manages the service:

- Member and service details entered in Availity transferred to EviCore — you don't need to enter the same information again.
- After submitting the request, you can check status updates in both the Availity and EviCore portals.

What you need to do

- Continue using the Is Authorization Required feature in our **provider portal on Availity**.*
- If authorization is needed, select "Take me to EviCore."
- Make sure you have both an Availity account and an EviCore account.

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How to submit a corrected claim

Learn more about what steps you need to take so we don't deny your resubmitted claim.

A corrected/replacement claim is a correction or replacement of a previously submitted claim, such as changes or corrections to charges, dates of service or member information. A void/cancel claim is used when a previously submitted claim needs to be eliminated in its entirety.

If you need to submit a corrected claim, wait for the original claim to be processed before doing so. Be sure to bill all lines, not only the corrected line(s).

See the chart below for details. If you resubmit your claim without following the instructions below, your claim will be denied as a duplicate claim.

Claim submission type	**Instructions**
Electronic We prefer to receive via EDI transaction in: • Loop 2300 of an 837I (Institutional) claim • Loop 837P of a Professional claim	**Frequency Code field (required field)** In CLM segment for CLM05-3, enter one of the below indicators: • 7 for replacement of prior claim • 8 for void/cancel of prior claim **Original claim number field (required field)** In REF segment Payer Claim Control Number field: • REF01 must contain F8 • REF02 must contain the payer's original claim number (the Aetna® claim number)
Paper	**Frequency Code field (required field)** CMS-1500 professional claim form — In box 22 Resubmission Code, enter one of these: • 7 for replacement of prior claim • 8 for void/cancel prior claim UB-04 facility claim form — In box 4 Claim Frequency Type Code, enter one of these as the 4th digit:

	• 7 for replacement of prior claim. Example 0137 — correction to a hospital outpatient claim • 8 for void/cancel prior claim **Original claim number field (required field)** CMS-1500 professional claim form — In the Original Ref. No field of box 22, enter the payer's original claim number. UB-04 facility claim form — In box 64 Document Control Number, enter the payer's original claim number.

Put interoperability to work: steps to strengthen your practice's connectivity

Learn more about the steps your practice can take to reduce administrative burden.

We're advancing interoperability, the secure, real-time exchange of health information, so the right patient data reaches you when it matters most. In our 2026 Q2 provider survey, 68% of providers cited disconnected systems as their top technology challenge, and 47% said real-time data access could save more than 10 minutes per appointment.

Prior authorization (PA) is a major focus area. We've standardized 88% of PA volume, exceeding one of our America's Health Insurance Plans (AHIP) voluntary industry commitments. Today, 82% of electronic PAs are approved in near real time, and 95% of eligible PAs are approved within 24 hours, with some approved in just a few hours.

Even better, the PA process can remain within your existing workflow. For example, Electronic Medical Prior Authorization (eMPA) enables providers to request, submit and track PAs directly within Epic. This streamlines PA by eliminating manual processes such as portal logins, faxes and external workflows, accelerating turnaround times, reducing administrative burden, and keeping care teams informed without disrupting their workflow. This capability is now live across more than 27 health systems.

What you can do today

Submit PAs using standard 278 Electronic Data Interchange (EDI) transactions or ask your EHR vendor about Fast Healthcare Interoperability Resources (FHIR)-based Coverage Requirements Discovery (CRD), Documentation Templates and Rules (DTR), and Prior Authorization Support (PAS) workflows that support the PA API required by Centers for

Medicare & Medicaid Services (CMS)-0057. These options can streamline PA and speed decisions, where available.

Taking these steps now can help your practice reduce administrative back-and-forth and put complete patient information in front of your care team when it's needed most.

Look for future OLU updates as we expand EHR connectivity and PA capabilities.

Getting ready for digital ID cards

Take these steps to prepare your practice.

We're moving toward a digital ID card experience, making it easier for members to access their insurance information at the point of care. Some of our commercial members already use digital ID cards today, and access will expand to additional members through early 2027. We'll continue to assess expansion to other lines of business while following applicable state requirements.

Digital ID cards display the same information as physical cards and support both Epic Payer Platform (EPP)-integrated and non-EPP workflows. They can help your practice verify eligibility more efficiently, reduce check-in administration and provide access to the most current insurance information. Clear, high-quality images may also reduce photocopying while giving members convenient access to their ID cards from a mobile device.

What you can do today

- If your practice uses EPP: Enable the Coverage Finder and Digital ID Card Exchange. These features bring coverage details directly into your registration workflow, eliminating the need to scan cards or manually verify information.
- If your practice doesn't use EPP: Review your check-in process and prepare to accept digital ID cards through another method, such as patient portal upload, email submission, manual entry or photo capture of the digital card.
- Continue accepting physical cards: Members may present a physical ID card at any time. Your existing eligibility verification process remains unchanged.

Get your practice ready

Review your check-in workflow with your registration team and determine how your practice will accept digital ID cards. Enable available EPP features or confirm the approved process staff should follow when members present a digital ID card.

We're committed to communicating proactively and partnering with our network throughout this transition. As implementation progresses, we'll continue to share additional details and guidance in future communications.

Coming soon: changes to your PA experience on Availity®

We're making the prior authorization (PA) process simpler and easier to navigate.

We're committed to simplifying the PA process. Beginning in January, you'll see enhancements to the PA workflow when you use our **provider portal on Availity**.*

If you use an Electronic Health Record (EHR) platform, refer to "**Put interoperability to work: steps to strengthen your practice's connectivity**."

We're adopting new clinical documentation standards

To help address variations in payer-requested information, we're adopting **clinical documentation standards**. These standards help make the PA process simpler, faster and easier to navigate. You'll see the same question-and-answer prompts for the same procedure groups among all participating payers. You'll already know what the questions are and how to answer them.

What you'll see on Availity

We're introducing the clinical documentation standards in the PA workflow on Availity. When you submit a PA request for one of the identified procedure groups, we may approve your request. Or we may pend it and ask you for additional information by completing an Aetna® clinical questionnaire or the standardized questions. We'll share the final list of procedure groups for which we may ask you to complete a clinical questionnaire or new question set soon.

Though answering the questions is optional, we strongly encourage you to answer them to reduce or eliminate requests for clinicals later. If you're using an EHR, you'll see the same standardized questions and answer prompts in the Documentation Templates and Rules workflow.

More information

Now's a great time to **register for Availity** if you're not already registered. Once your account is ready, you can start using it immediately. Take advantage of the training resources to learn how to submit PA requests and upload supporting documentation through the site.

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

2027 Aetna Smart Compare® is coming soon

Evaluation notifications were sent in November 2026.

The Aetna Smart Compare program

Aetna Smart Compare is a provider designation program that evaluates our participating providers, identifying those that meet higher standards of quality and cost-effectiveness. The national program began in 2021 and has continued to expand by specialty.

In 2027, we're expanding our measurements of behavioral health to include psychologists and other talk therapists, including counselors and social workers. Previously, we included only psychiatrists.

Evaluation notification

In November 2026, we notified physicians we've evaluated. These physicians can go to our **Aetna Smart Compare Designation** page and refer to the Aetna Smart Compare Methodology Guide to access the latest standards and measurements applicable to the evaluation period.

Evaluation period for 2027

The 2027 designations for Aetna Smart Compare evaluate claims data from 2024 and 2025.

How to dispute a designation

Physicians will have an opportunity to dispute their designation status before it's published through a process that includes the following protections:

- Before we make results public, we'll provide at least 45 days' written notice of the designation, including the methodologies, data and all other information we used to arrive at the designation.
- Physicians can request a fair reconsideration proceeding within 45 days of receiving the written notice.
- All reconsiderations begun in the first 45 days may lead to reversing our decision for your practice, regardless of the length of our exchange.

Proper coding for women's cervical cancer screenings

Accurate coding helps your patients get the coverage they're entitled to.

The Health Resources and Services Administration (HRSA) finalized updates to the women's cervical cancer screening guidelines, effective January 1, 2027. The HRSA recommends

that women receive routine cervical cancer screenings between ages 21 and 65; methods and frequency may vary.

For example, patient-collected, high-risk human papillomavirus (hrHPV) testing is considered an appropriate method of testing. Supplementary testing (e.g., cytology, biopsy, colposcopy, extended genotyping and dual stain) and pathology evaluations could also be considered 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 testing and the accompanying pathology services — when performed in conjunction with routine preventive cervical cancer screenings — are considered preventive care. Claims for these services should be submitted with a preventive diagnosis code to distinguish them as such.

The departments listed 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.*

Accurate coding can prevent unexpected cost sharing for your patients and ensure that they receive the coverage they're entitled to.

*CPT® is a registered trademark of the American Medical Association. 2025 All rights reserved.

How to contact us about utilization management (UM) issues

You can contact us during or after business hours.

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.
- Call the patient management and precertification staff using the Member Services number on the member's ID card.
- 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.

Responsive care can help your practice

You can earn a digital Care Champion badge for your provider profile.

To help us assess and improve the member experience, we conduct the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Through this survey, members share feedback about their experiences accessing care and finding providers who meet their individual needs.

Members are asked:

- How often were you able to find a health provider who met your cultural, racial or ethnic needs or preferences?
- How often were you able to find a health provider who met your language needs or preferences?

These responses help us understand how well our network supports members from diverse backgrounds and identify opportunities to enhance care.

Language

Our members have access to no-cost translation and interpretation services, including TTY/TDD services for members who are hearing impaired, by calling the number on the back of their ID card.

We can help you strengthen your practice's commitment to inclusive care

Our **clinical educational hub** includes courses on topics to help improve member engagement and access. You can earn a digital Care Champion badge for your provider profile in three clinical areas of focus. Claim a badge after completing the free, on-demand accredited courses and we'll add them to your profile. Members will also see it in our provider directories.

Courses include:

- **Culturally Responsive Care**
- **LGBTQ+ Responsive Care**
- **Culturally Responsive PCP Behavioral Health Care**

Promote interpreter services, encourage culturally responsive communication and consider earning a Care Champion badge to demonstrate your commitment to providing inclusive, member-centered care.

2027 Medical record documentation requirements

Ensure your medical records adhere to established criteria.

We've established medical record criteria, which provide 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. Required elements include:

- Entries that are dated and legible with member ID present on each record page
- Working diagnosis/reason for visit
- History & Physical, including past medical history
- Current problem list (medical and behavioral health)
- Prescribed medications, including dosages and dates of initial or refill
- Medication allergies or No Known Drug Allergies (NKDA) notated
- Treatment plan
- Lab/studies ordered with evidence of physician review of results
- Documentation of communication if referral to specialist
- Preferred language and if applicable offer of qualified interpreter (California only)
- Advance directive documentation for Accreditation Association for Ambulatory Health Care (AAAHC) plans only

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. You can find our medical record criteria and best practice documentation guidelines in the **Office Manual for Health Care Professionals**.



Behavioral health

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

Refer patients to our Behavioral Health Care Management program

Our Behavioral Health Care Management program is a collaborative process that includes the Aetna® clinician, member, caregiver and providers.

We thoroughly assess the member's physical and emotional health, including the member's current condition, presence of co-existing mental health and substance use disorder issues, and treatment history. We give patients with complex conditions extra help understanding their health care needs and benefits. We also help them access community services and other resources available to them.

Improved Outcomes

Members who participate in at least 60 days of Behavioral Health Care Management have been shown to have significantly reduced behavioral health symptoms. Assessments completed upon enrollment and case closure for these members show an average of 25 to 35% reduction in symptoms of depression and anxiety.

How members get connected

Our goal is to produce better health outcomes while managing health care costs. We welcome referrals to the program from many sources. These include:

- Primary care physicians
- Specialists
- Facility discharge planners
- Family members
- Internal departments
- The member's employer
- Organization programs
- Vendors or delegates

You can submit a referral in two ways:

- Call: **1-800-424-4660 (TTY: 711)**
- Email: **AetnaBehavioralHealthReferrals@aetna.com**

More information

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

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, call our Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** to get 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
- Behavioral health screening programs
- Our behavioral health quality program

More information

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

We value your responses to our annual practitioner surveys

Your participation in the 2027 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.

More information

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

Follow-up care for ADHD

We encourage you to work with patients, care providers and schools for better outcomes.

We use HEDIS® (Healthcare Effectiveness Data and Information Set) to measure improvement in clinical outcomes for members.*

One measure that we monitor is the ADD-E measure, which is the rate of members from age 6 to 12 on ADHD medication with at least three follow-up care visits within 10 months of the first ADHD medication being dispensed. A typical breakdown is as follows:

- The Initiation Phase (a follow-up visit with a prescribing provider within 30 days of receiving medication)
- The Continuation and Maintenance Phase (continued ADHD medication for at least 7 months after the initiation phase in addition to receiving two additional follow-up visits within 9 months after the initiation phase)

Best practices

The **American Academy of Pediatrics** and **American Academy of Child & Adolescent Psychiatry** provide recommendations for best practices when treating ADHD such as:

- Explaining medication options and side effects
- Discussing therapy, support groups, social skills training, and/or parenting skills
- Scheduling follow-up visits for medication management
- Collaborating with other medical providers and the school

Partner with patients for improved outcomes

Partnering with parents and service providers helps ensure that patients understand the importance of keeping appointments. Using a combination of medication, therapy and classroom interventions can improve awareness of the importance of follow-up care and medication adherence. It may also promote calmer relationships with family members, better study habits and more independence in children.

Collaboration between the prescribing physician, therapist and school is important for success. Parents and caregivers can better understand their child's condition through accessing resources such as the following:

- **Support groups**
- Parent resources such as **Tilt Parenting**
- Medication alerts/reminders
- Counseling
- Local school districts

More information

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

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Medicare

Get Medicare-related information, reminders and guidelines.

Medicare GLP-1 Bridge program

Learn more about coverage and routing guidance.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) launched the Medicare GLP-1 Bridge, a temporary program providing eligible Medicare Part D members access to certain GLP-1 medications for weight management for a limited time.

Clear routing of GLP-1 requests helps reduce administrative burden, improves turnaround times and ensures members receive the right coverage through the appropriate channel.

How the GLP-1 Bridge works

The GLP-1 Bridge operates outside of the Medicare Part D benefit. CMS manages prior authorization (PA), claims adjudication and pharmacy payment through a central process.

Part D plans aren't financially or administratively responsible for medications dispensed through the GLP-1 Bridge.

Coverage and routing guidance

To minimize delays and rework, it's important to route requests correctly:

- Use Part D for GLP-1 prescriptions tied to covered conditions (e.g., Type 2 diabetes, cardiovascular risk reduction and certain sleep apnea indications).
- Use the GLP-1 Bridge only for eligible weight management requests that aren't otherwise covered under Part D. Members who qualify for the Bridge program can't use any discounts or coupons to help pay for medications. The cost is a flat $50 per month.

Members who qualify for Part D coverage aren't eligible for the GLP-1 Bridge and should continue through standard benefit processes.

What this means for you

- Continue to follow existing Part D PA and formulary exception processes.
- Don't redirect requests that meet Part D coverage criteria to the GLP-1 Bridge.

- Support appropriate routing for eligible weight management requests to reduce unnecessary denials and resubmissions.

Align your prescribing, PA and intake workflows to ensure that GLP-1 requests are routed correctly the first time. Proactively educate clinical and administrative staff on Part D versus GLP-1 Bridge criteria to reduce avoidable denials, rework and delays in member care. For assistance, visit the **CMS website** or call **855-273-0102**.

Complete your required Medicare compliance training and attest by December 31, 2026

In late spring of this year, you received a training and attestation notice via your compliance email address. If we don't have your email address, you received a postcard reminder requesting completion by October 31, 2026.

If you're participating in our Medicare Advantage (MA) plans, you 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, 2026, to remain compliant. Note: Extensions beyond this date won't be granted.

EyeMed is the in-network provider for routine vision benefits for Aetna® Medicare Advantage (MA) and Allina Health | Aetna Individual plan members

Find out how to join the EyeMed network, check eligibility and get claims paid.

This article doesn't apply to the following:

- *Florida*
- *Select integrated D-SNPs, including the Aetna Medicare FIDE (HMO D-SNP) in Illinois, New Jersey and Virginia and Aetna Medicare HIDE (HMO D-SNP) in Michigan*
- *Aetna Group MA plan members*

Aetna MA and Allina Health | Aetna 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. This change became effective on January 1, 2026.

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.*

Reimbursement

Aetna and Allina Health | 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. Refraction should be billed as inclusive to the routine eye exam.** $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. Refraction should be billed as inclusive to the routine eye exam.** $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 and refraction up to $50.** Members are responsible for any billed amount over $50. $0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.

Claims

Refer to the following breakdown for help with how to bill:

- For routine exams and eyewear
    - Submit routine supplemental Medicare vision claims (eye exams and eyewear) directly to EyeMed for faster processing and payment.
    - Claims for routine vision exams and eyewear should be submitted to EyeMed directly. Don't submit routine vision claims to Aetna.

- For refractions
    - Please bill EyeMed for all refractions, since they are covered under the routine vision benefit (not the medical benefit). If a refraction is performed during a diagnostic eye exam, submit the diagnostic eye exam to Aetna, and submit the refraction separately to EyeMed.
    - An annual eye exam includes one covered refraction per year. If a refraction is performed as part of a medical eye exam or routine eye exam, the member is not eligible for an additional refraction in the same year.

- For nonroutine services
    - For non-routine services or claims with a medical diagnosis, follow standard medical billing guidance.

- For cases where you are a non-EyeMed provider

  Mail claim forms to:

  First American Administrators, Inc.
  Attn: OON Claims
  P.O. Box 8504
  Mason, OH 45040

Verify whether you're 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, including but not limited to lab work, diagnostic testing, and/or specialist treatment, they may also be responsible for the cost for the additional services.

Aetna® Individual Medicare Advantage (MA) 2027 plan expansion

You might be a participating provider for the new counties.

We're expanding our Individual MA plans to **60 new counties (PDF)** for 2027. 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, 2026, and ends December 7, 2026. We believe that Medicare beneficiaries will be interested in our plans because of our healthy Star Ratings. For 2027, our overall enrollment-weighted rating is 3.98 out of 5 stars (measurement period FY 2025 and early 2026). 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**.

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

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