September 2026

OfficeLink Updates™

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

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Digital prior authorization (PA) can help your practice

We want to make health care easier to navigate — for you and your patients — by simplifying administrative processes and strengthening our partnership with your practice.

Remember to refer patients to in-network pharmacies

If you typically refer patients to a pharmacy that is leaving the network or if you've been referring patients to an out-of-network pharmacy, you'll need to identify an appropriate in-network one.

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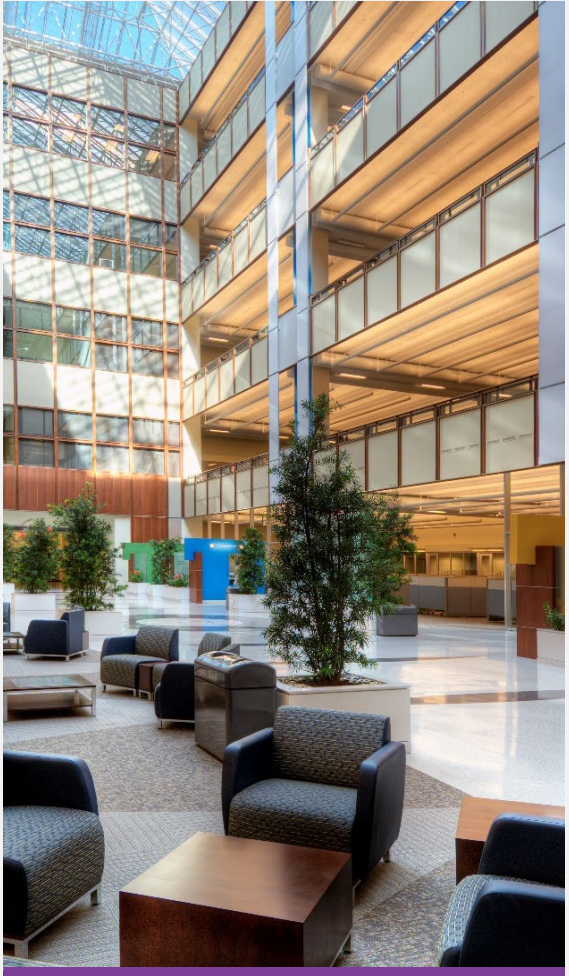

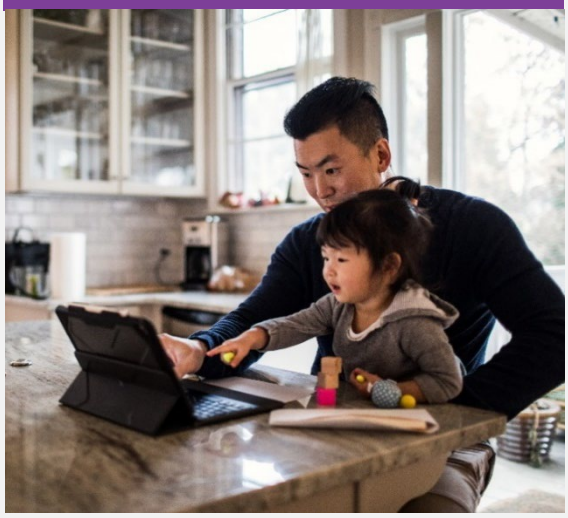

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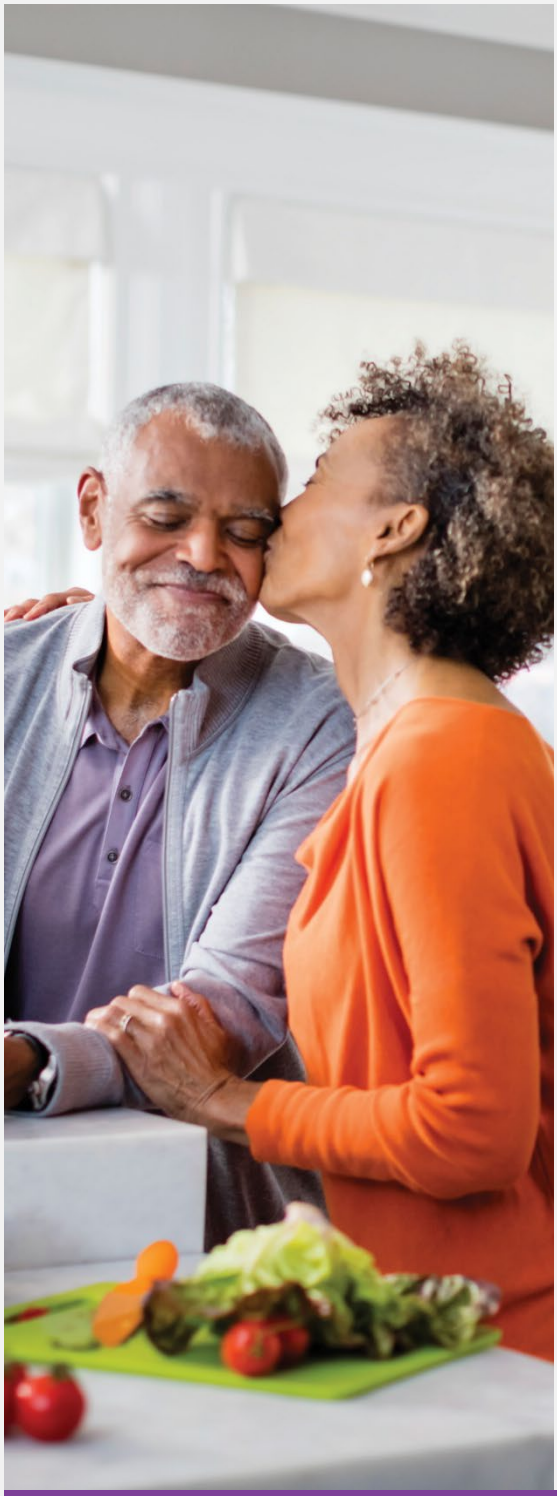

Important policy updates (including pharmacy)

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 December 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 December 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 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 prenatal office visits

Routine prenatal and postpartum office evaluation and management (E&M) visits are considered preventive services and have no member cost-share. These visits are to be submitted with modifier TH and are distinguished from non-routine prenatal and postpartum office E&M visits by the diagnosis code linked to the specific office E&M visit. Modifier TH alone doesn't determine a service is considered preventive. Non-routine prenatal and postpartum E&M office visits shouldn't be submitted with modifier TH and are subject to member cost-share.

Starting September 1, 2026, we encourage you to review the preventive prenatal office visit guidance available through our updated Routine Preventive Care Benefit Guidance statement on our **provider portal on Availity**.**

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 are provided 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 and postpartum periods should be documented and billed based on the medical reason for the encounter. We encourage you to review updated maternity coding guidance before the 2027 implementation.

More 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 becomes 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 January 1, 2027, 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 October 1, 2026. 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 our **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.

How to verify that your patient has a chronic condition

You can use our automated phone system to quickly and securely verify a patient's chronic condition, as required by CMS.

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.

Why you need to verify

Verifying a patient's chronic condition helps ensure that they remain enrolled in their Aetna® Chronic Condition Special Needs Plan (C-SNP) and continue receiving the care and support they need to manage their condition.

Be sure to verify as soon as you can but no later than 60 days after the patient's C-SNP effective date. If we don't receive verification, the patient must be disenrolled in accordance with the Centers for Medicare & Medicaid Services (CMS) requirement.

Now you can verify by phone

Our automated phone system is a quick and easy way to verify one or multiple patients in a single call.

To verify a patient's chronic condition by phone:

1. Have the patient's name, date of birth, and your NPI or TIN ready.
2. Call the Medicare provider number listed on the **Contact Aetna** page **(1-800-624-0756) (TTY**: **711)**.
3. Follow the automated prompts to submit the chronic condition verification.
4. Keep the reference number provided at the end of the call for your records.

This fast, easy process helps you complete verification in just a few minutes, without needing to submit a paper form.

Other self-service verification options

You can also verify a patient's condition using these secure, self-service methods:

Method	Submission details
Download the **Verification of Chronic Condition (VCC) Form**	Complete and submit the form. • Include a cover sheet and fax the form to the Enrollment Department at **1-844-749-2651**. • Or send the completed form securely by email to **VCC@Aetna.com**.
Sign and submit electronically	If an email address was provided by your patient, we'll email you a VCC form that you can sign electronically and return securely to Aetna.
Submit through the provider portal	If an email address was provided by your patient, we'll send you an access code so you can submit the VCC form electronically through **Availity**.*

Who can confirm a chronic condition

A patient's chronic condition must be confirmed under the authority of a licensed health care provider (MD, DO, NP or PA) involved in the member's care. Authorized office staff may assist with completing or submitting the confirmation, but the provider's NPI will need to be validated.

How to reach us

Use the phone number provided in your outreach materials or dial **1-800-624-0756 (TTY: 711)**.

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

Biennial medical records audit 2026

Prepare your office in case it's randomly chosen.

This article applies to the following states: California, Colorado, Florida, Illinois, Nebraska, Nevada, New York, Oklahoma, Pennsylvania, Tennessee and West Virginia.

During the fourth quarter of 2026, we'll audit medical records in certain states to comply with state regulatory requirements set forth by individual state Departments of Insurance (DOI).

You can find our medical records requirements and scoring criteria in the **Office Manual for Health Care Professionals (PDF)**. Your contract with us requires your participation in quality improvement activities, which includes supplying copies of medical records.

Audit requirements

If you're chosen for the audit, you should send all of the following information for the time frame of January 2025 through December 2026:

- Face sheet (demographics) or member snapshot
- Signed office visit notes, to include:
    - Medical history and diagnoses
    - 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 specialists
- Discharge summaries from hospitals, acute rehab or skilled nursing facilities (SNFs)
- For California only: documentation of member's preferred language and offer of a qualified interpreter (or refusal if the member declines)

What to do next

Please fax or email records within 14 days of the request to the specific auditor shown on 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.

Aetna® Market Fee Schedule (AMFS) update

This article applies to the following states: Alaska, Connecticut, Idaho, Maine, Massachusetts, New Hampshire, Oregon, Rhode Island and Washington.

We're updating our AMFS for plans in your service area. These changes will affect the services we pay you for based on AMFS. You can find these services in the compensation section of your contract. The following states will see changes:

- Effective October 15, 2026: Alaska, Idaho, Oregon, Washington

- Effective November 1, 2026: Connecticut, Maine, Massachusetts, New Hampshire and Rhode Island

How we determine our fee schedule

We look at industry standards and other sources, such as the Resource-Based Relative Value Scale (RBRVS) on the Centers for Medicare & Medicaid Services (CMS) website.

- For codes using RBRVS, we use the site-of-service differential. This lets us make additional payments for certain codes based on the service location.
- For codes where RBRVS is either not used or not available, we use sources like external vendor pricing models, Medicare fee schedules and nationally contracted rates.

View the fee schedules

The updated fee schedules will be available to view as follows:

- October 15, 2026, for Alaska, Idaho, Oregon, Washington
- November 1, 2026, for Connecticut, Maine, Massachusetts, New Hampshire and Rhode Island

You can view them on our **provider portal on Availity**.* Or go to **Aetna.com**. Choose “more Aetna” then “medical providers.” Then choose “claims.”

We’re here to help

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

California: Provider dispute address change

Effective immediately, California Health Maintenance Organization (HMO) provider disputes not submitted through our **provider portal on Availity** should be mailed to:*

P.O. Box 14020
Lexington, KY 40512

Please note that the Fresno office has closed.

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

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Georgia: Prior authorization (PA) exemption program ("Gold Carding")

We'll notify you if you're eligible for this program.

Effective July 1, 2026, we began offering a PA exemption program ("Gold Carding") that applies to Georgia fully insured commercial plan members (identified by "FULLY INSURED" on the ID card) in accordance with Georgia state law (Ga. Code §§ 33-46-20.1).

Providers who submitted at least 10 PA requests in the prior calendar year for a specific health care service or drug on our participating provider precertification list (excluding inpatient confinements) and had a 90% or higher approval rate for those requests are qualified for an exemption from requesting PA for that service or drug.

You'll be notified if you're eligible for this exemption program. We'll review eligibility for new exemptions annually and may audit claims to confirm that you continue to meet exemption requirements.

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

Illinois: Uniform Electronic Provider Directory Information form now available

Use the form to update our directories.

The Illinois Department of Insurance (DOI) has adopted a Uniform Electronic Provider Directory Information form (Uniform Directory template) after receiving feedback from a task force last year. This template can be found on the **DOI website**.

Effective July 1, 2026, onboarding, current and terminating providers are required to use this form to supply issuers with information to populate in its provider directories. Issuers are required to provide, accept and implement these templates using the information from its providers.

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 your demographic information so long as you can attest that your existing data remains accurate except for any of the fields you've updated on the template you submit.

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

Louisiana: Keep hospital/facility participation status updated

The law applies to hospitals and ambulatory surgical centers (ASC); and hospital/facility-based physicians and groups (anesthesia, radiology, pathology, emergency medicine, neonatology).

Louisiana law requires hospitals and other medical facilities to report to each health plan the network status of hospital-based providers (anesthesiologists, pathologists, radiologists, neonatologists and emergency medicine physicians) who provide medical services at that facility.

Why this matters

Accurate provider information allows us to:

- Help your patients make informed care decisions and avoid getting a surprise bill
- Know which providers practice at contracted facilities
- Meet our obligations to clearly indicate provider specialty

How you can help

To ensure accuracy, regularly update your information.

- For hospitals/ASCs, please submit a roster containing a list of the groups or individual physicians that provide anesthesiology, radiology, pathology, emergency medicine and neonatology services at your hospital/ASC.

  Here's an example:

Name of physician or physician group	National Provider Identifier (NPI)	Specialty	Physical address	Phone number
		Pathology		
		Radiology		
		Anesthesiology		
		Emergency medicine		
		Neonatology		

- For hospital/facility-based physicians and groups, submit the hospital/ASC name, address and phone number where you provide services.

After your initial submission, send updates within 30 days of any change.

How to send information

Please send current rosters and ongoing updates to us **via email** (subject line: Provider Data Update — [Provider Name])

Questions?

Our team members are **happy to assist** if you have questions or need support with submissions.

Nebraska: Prior authorization (PA) API availability

Find out more about the electronic transactions this Application Programming Interface (API) will support.

Effective January 1, 2027, the PA API will be available to you as part of our ongoing efforts to support interoperability. You don't have to take any action.

What this means for you

This API supports the electronic exchange of PA information using industry-standard interoperability technology. It will be available to your electronic health record or provider system technology partners. To learn more, access our **Developer Portal**.

Beginning January 1, 2027, the PA API will support transactions including:

- Determining PA requirements
- Retrieving required questionnaires and documentation
- Submission of PA requests
- PA status inquiries

The API will complement existing PA submission channels and provides an additional electronic option for exchanging PA information with us.

More information

For more information on existing PA resources and tools, visit our **provider portal on Availity**.* For technical support and API questions, visit our **Developer Portal Support**.

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Nevada: Effective date change for prior authorization (PA) for SNF and IRF episode management

This information applies to Medicare Advantage (individual and group) and Dual Eligible Special Needs Plan (D-SNP) members only.

In our **June 2026 quarterly OLU newsletter** (page 19), we said that, effective August 1, 2026, WellSky™ will manage all PA requests for Skilled Nursing Facility (SNF) and Inpatient Rehabilitation Facility (IRF) episode management.

The effective date has been changed to September 1, 2026.

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 every month, from 1 PM to 2:30 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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How digital submissions can speed up claims processing and dispute resolution

Move beyond fax and paper.

Getting the right information submitted quickly helps your claims and disputes move forward faster. You don't have to rely on fax or paper to do it.

Your digital options today

You can share documentation with us electronically by:

- Uploading attachments in our **provider portal on Availity***
- Sending attachments through your clearinghouse (EDI 275 transaction)
- Using data exchange through select Electronic Medical Record (EMR) systems
- Submitting initial disputes using Availity®

Why this matters

Using digital submission tools helps you:

- Spend less time faxing, scanning and tracking paperwork

- Reduce delays and follow-up requests
- Clearly see what's needed and what's already submitted
- Get faster claim and dispute decisions
- Free up staff time to focus on patient care

What's changing

New industry standards for electronic claim attachments and signatures are accelerating the shift away from manual processes and toward faster, secure digital exchange.

Here's what you can expect soon:

- Medical Attachments Dashboard on Availity: View claims that need more information
- More attachments per claim: Submit up to 10 files (64 MB each)
- Expanded Electronic Remittance Advice (ERA) codes: More reason and remark codes

Similar digital transformation efforts are underway for prior authorization (PA). To learn more, see "**Digital prior authorization (PA) can help your practice**."

Get started

These tools are built to support your workflow and make it easier to submit claims and disputes. Log in to **Availity** to get started.

Questions?

If you need help, contact your clearinghouse vendor first. If Availity is your vendor, you can contact them at **1-800-282-4548**.

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

See more commercial claim details in your ERA

These changes will help you understand what's needed sooner.

Beginning in early August 2026, your Electronic Remittance Advice (ERA) began showing more details for some commercial claims when we needed more information.

What's changed

- Your ERA includes claim adjustment and remark codes to help explain what information is needed.

- In the Claim Status Inquiry (CSI) Transaction, category codes P3 and P4 changed to F2.
- The 277P transaction is no longer available. Use your ERA to view claim details.

What to do next

- Check your ERA for claim details and next steps.
- Submit requested information using our **provider portal on Availity**.*
- Don't use the Appeals form or dispute addresses to send additional or supporting documentation.

You'll still have time to respond if we need more information. Sending it early can help reduce delays.

Questions?

If you need help, contact your clearinghouse vendor first. If Availity® is your vendor, you can contact them at **1-800-282-4548**.

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Digital prior authorization (PA) can help your practice

Prepare to meet the evolving Centers for Medicare & Medicaid (CMS) requirements.

We want to make health care easier to navigate — for you and your patients — by simplifying administrative processes and strengthening our partnership with your practice.

A core priority is to move PA fully into Electronic Health Record (EHR) workflows. This shift is designed to reduce manual steps, accelerate decision-making and help you deliver timely care to your patients.

Activate digital PA functions within your EHR system

Work with your existing EHR vendor to assess capabilities that may already be available but not yet activated to enable digital PA functionality. For example:

- Clinical Data Exchange (CDE): Automate submission of requested clinical data
- Electronic PA Submission: Submit the electronic PA using either the EHR connectivity to Aetna® or direct connect with Aetna.
    - EDI — EDI connection use 278R or 278N request types to automatically send electronic authorizations to Aetna (For example, the eMPA connection from Epic uses this channel for connected providers).

- Fast Healthcare Interoperability Resources (FHIR) — CMS0057 Compliance — CMS mandates three new workflows to submit PA from providers to payers. As part of this compliance need, you can integrate either directly or through your EHR to Aetna using Coverage Requirement and Discovery (CRD), Document Template and Rules (DTR) and Prior Authorization Support (PAS) workflows.

If you have outsourced your PA capabilities to a third-party vendor or administrator, reach out to them to discuss ways to enable digital PA functionality.

If your practice leverages a custom EHR, consider direct connectivity using an Application Programming Interface (API) to enable seamless data exchange.

Claims and disputes

Our digital transformation also includes standardizing and enhancing claims and disputes. Refer to "**How digital submissions can speed up claims processing and dispute resolution**."

Get answers faster with our new AI-powered chat on Aetna.com

As part of our continued focus on improving the provider experience, we're expanding digital tools that simplify your everyday tasks. A new addition — artificial intelligence (AI)-powered chat — is now available on our provider pages. The chat will help you and your staff get quick answers to common questions right when you need them.

Discover how we're investing in tools and processes that give you more time for patient care on **Aetna.com**.

How this helps your office

You'll experience the following:

- Quick answers: Get general information about claims, appeals, billing, prior authorization (PA), network participation, forms and CPT codes — no login required.
- Less searching: The chat pulls from multiple Aetna® resources at once, saving time spent navigating pages, PDFs or portals.
- Available 24/7: Use the chat anytime — day or night — to get answers when it works best for you and your staff.

How to access the chat

Visit our provider pages and select the Chat icon in the lower-right corner to start a conversation.

This chat provides general information only and is accessible prior to authentication. For account-specific details, claim status, or patient-level information, please log in to your provider portal.

Remember to refer patients to in-network pharmacies

This information applies to all facilities, including skilled nursing facilities (SNFs), long-term care (LTC) facilities and hospitals.

If you typically refer patients to a pharmacy that is leaving the network or if you've been referring patients to an out-of-network pharmacy, you'll need to identify an appropriate in-network one.

You're required by contract to refer patients to in-network providers, which includes pharmacies. For more information, please refer to our **Provider Manual** and our **Provider and Facility Participation Criteria**.

You can refer to **this list of in-network pharmacies** to search for an in-network pharmacy provider.

Aetna HealthFund® (AHF) plan Health Reimbursement Account (HRA)

Learn more about how to identify members and check their available funds.

The AHF HRA is a national reimbursement account, or health fund, that accompanies some medical health plans. Health funds pay toward a member's deductible until it's met.

You shouldn't request payment from these members up front, since their fund dollars are applied to their claims when you submit them to us. If a member's health fund becomes depleted and the member hasn't yet reached their deductible, the member is responsible for the cost of covered services until the deductible is met.

Once the deductible is met and the health fund is exhausted, the underlying medical plan starts to pay.

How to identify AHF members

Go to the Eligibility and Benefits response screen and look under Plan/Product to see if AHF is listed there.

How to check whether the member has funds available

Look at the message "Health Fund," under "Limitations." You'll see the remaining dollars available to apply toward the deductible. This amount is based on claims that we have fully adjudicated.

If you see funds there, you should bill the claim to us. Don't ask for money up front.

Non-pharmaceutical interventions (NPIs)

Help prevent care gaps for FEHB and PSHB patients.

We're committed to helping our federal members achieve their best health outcomes. Aetna® plans that cover members through the Federal Employees Health Benefits (FEHB) or Postal Service Health Benefits (PSHB) programs offer benefits and discounts that support NPIs.

NPIs have been demonstrated to prevent or delay costly complications of disease for obesity, hypertension, and diabetes including nutrition and lifestyle counseling, intensive behavioral therapy, supervised exercise therapy, physical therapy, stress management/mental health support via psychotherapy and cognitive behavioral therapy, pain management and collaborative care models.

We encourage you to use alerts within Care Considerations to help identify potential care gaps, inform members about available Aetna Care Management programs, and incorporate NPIs into individualized care plans.

Please encourage members to review their Official Plan Brochures for information on available benefits when appropriate.

Check your Aetna Premier Care Network (APCN) status for 2027

Use our provider referral directory to find out if you participate.

Please check our **online provider referral directory** to see whether you participate in our APCN/APCN Plus programs for 2027. If you have questions, refer to our **Contact Aetna** page.

Notable 2027 APCN changes

- Kentucky: High Performance Network market withdrawal
- Western/Grand Rapids, Michigan: High Performance Network market expansion to Clinton, Eaton, Ingham and Shiawassee counties
- Oklahoma City: High Performance Network service area removal of Grady and Pottawatomie counties

Notable 2027 APCN Plus changes

- Kentucky: High Performance Network market withdrawal
- Western/Grand Rapids, Michigan: High Performance Network market expansion to Clinton, Eaton, Ingham and Shiawassee counties

Overview of APCN/APCN Plus

APCN is a performance network for businesses with employees in locations across the country. With this network, employers can offer a single benefits design and simplified communications to all employees, regardless of their location.

APCN Plus concentric and multi-tier includes a combination of performance networks across the country, but also includes Accountable Care Organizations (ACOs) and joint ventures (JVs) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card for identification.

Update your hospital admitting privileges and demographic information

Doing so will help us process your claims and help patients find you.

Your contract with us requires that you keep your demographic information updated. It's a good idea to do this at least once a year.

You should verify the following information:

- Hospital admitting privileges
- Practice addresses
- Phone and fax numbers
- National Provider Identifier (NPI)
- Office hours

Maintaining up-to-date provider information helps support:

- Accurate directory listings

- Claims processing and payment
- Faster credentialing and recredentialing
- Improved patient access and communication

Please submit your changes through our **provider portal on Availity** by using the Manage My Organization feature.* To get there, go to the top-right corner of the navigation bar and select the drop-down menu that shows your name. Then choose “Manage My Organization.”

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

It’s important to keep your demographic information up to date

Giving us your race, ethnicity and language information is voluntary, but keeping your information current helps our members connect with you to get care. Update your information via Availity® using our how-to guide.

How we use demographic details

We share demographic details in our online provider directory. Patients can refer to them when searching for care. Our customer service representatives might provide these demographic details if a plan member requests them.

Giving us your race, ethnicity and language information is voluntary. You can request that this information be removed from your profile at any time.

It’s easy to update

The provider data management (PDM) tool on Availity* allows you to update information about your business and providers. Keeping your information current and accurate helps our members connect with you for care.

Making updates in the PDM tool allows you to share information with Aetna® and other payers, reducing phone calls to your office. Some other benefits include:

- Staying listed in provider directories
- Avoiding potential claims payment delays

Updating your information is easy. Simply log in to our **provider portal on Availity**. Navigate to My Providers and then to Provider Data Management. Update the languages you speak and your race. That’s it!

Update your profile in minutes

Follow the steps shown in our **quick reference guide**, which you can use for making updates on our **provider portal on Availity**. The guide will help you update essential information like:

- Email addresses
- Telehealth status
- Appointment phone number
- Mailing address
- NPI number
- Languages spoken by providers and office staff
- Race/ethnicity

More information

If you need further help, you can go to the **Learn about Provider Data Management** page. You'll find short demos about how to enter, update, validate and attest to demographic data in the Availity PDM application.

If you need to add a new provider to your practice, use **Aetna.com**.

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Our office manual keeps you informed

Refer to this manual for information about policies, utilization management (UM) decisions and medical record documentation.

Visit us online to view a copy of your **Office Manual for Health Care Professionals (PDF)**. The Aetna® office manual applies to the following joint ventures: Allina Health|Aetna and Banner|Aetna.

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:

- Policies and procedures
- Our complex case management program and how to refer members

- Additional health management programs, including Healthy Aging Support, the Aetna Healthy Chapters, Lifestyle Condition Coaching and others
- Member rights and responsibilities
- How we make UM decisions, which are based on coverage and appropriateness of care and include our policy against financial compensation for denials of coverage
- Medical Record Criteria, which is a detailed list of elements we require to be documented in a patient's medical record and is available in the **Office Manual for Health Care Professionals (PDF)**

How to reach us

Contact us by visiting our **Contact Aetna** page, calling the Provider Contact Center at **1-888-MD AETNA** **(1-888-632-3862) (TTY: 711)** and selecting the "precertification" phone prompt, or calling patient management and precertification staff using the Member Services number on the member's ID card. The Medicare phone number is **1-800-624-0756** **(TTY: 711)**. Our medical directors are available 24 hours a day for specific UM issues.

More information

Visit us online for information on how our quality management program can help you and your patients. We integrate quality management and metrics into all that we do, and we encourage you to take a look at the program goals.

Improving the patient experience: tips for your practice

Your efforts to enhance patient interaction will not only improve satisfaction but also drive better health outcomes.

Each year, we send a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to gather feedback from members about their overall health care experience, including their experience with their personal doctor.

Tips for how to improve the patient experience

Encourage open communication

- Use receptive body language (for example, sit down, lean in and maintain face-to-face engagement)
- Maintain eye contact with the patient and avoid interrupting
- Use simple, easy-to-understand language

Offer flexible access to care

- Consider offering evening and/or weekend appointments

- See patients within 15 minutes of their scheduled appointment or arrival time
- Call patients 24 to 48 hours before their appointments to confirm and remind them of any items they'll need to bring
- Explain after-hours access to the on-call physician, Aetna's after-hours nurse line and when to seek urgent versus emergency care

Keep the patient informed

- Consider providing a preventive health care visit at the same time as a sick visit
- Review the member's chart for any consults or specialist treatments prior to the visit
- Review all treatment options with the member and/or parents or guardians and encourage their input, questions and collaboration
- Provide handouts, brochures, diagrams and other educational materials to help members understand diagnostic tests, medications and prevention

Additional resources for office staff and patients

The 24-Hour Nurse Line

Our 24-Hour Nurse Line gives members ready access to registered nurses who can answer questions on a variety of health topics, which may help prevent unnecessary trips to the emergency room.

Aetna® care management

The Aetna One® care management program is transforming the health care experience through predictive analytics, personalized outreach and local access.

Our provider portal

Our **provider portal on Availity** helps reduce administrative time so you can focus more on patient care.* It offers a one-stop solution to efficiently perform key daily functions.

Cultural competency webinar

Watch this short **cultural competency video** to learn more about cultural competency and the important roles that you and your office staff play.

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Work with us to support your patients

You play a key role in helping patients get coordinated care.

Your responsibilities

Our care management (CM) programs support you by identifying high-risk members and sharing care information. Care managers assess medical, behavioral and social needs, develop care plans, and share updates, care gaps and utilization data. You're asked to incorporate this information into treatment planning and collaborate closely with care managers to ensure timely, coordinated care across settings.

Utilization management (UM) supports this work by identifying members through authorization requests, hospital reviews and utilization patterns. Prior authorizations (PAs) help UM complete timely reviews, deliver appropriate services, ensure smooth transitions of care and allow care managers to act quickly and coordinate next steps.

What this means for you

- Refer patients who need extra support.
- Respond to outreach and participate in care coordination.
- Use shared data to close gaps in care.
- Align care plans and reinforce patient goals.
- Share updates on condition, treatment or barriers.

Why this matters

Strong collaboration leads to better outcomes. It reduces duplicate services and supports smoother transitions of care. When you partner with CM and UM, patients get the right care at the right time.

Behavioral health

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

Behavioral health clinical practice guidelines

Find out more about the resources that can help you improve patient care.

Clinical practice guidelines from nationally recognized sources promote the use of evidence-based treatment methods. This helps provide the right care at the right time. We make them available to you to help improve health care.

These guidelines are for informational purposes only. They're not meant to direct individual treatment decisions. All patient care decisions are your sole responsibility.

Adopted guidelines

- **American Academy of Pediatrics (AAP)**: Clinical practice guideline for the diagnosis, evaluation and treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in children and adolescents (2019)
- **American Society of Addiction Medicine (ASAM)**: Clinical practice guideline on alcohol withdrawal management (2020)
- **American Psychiatric Association (APA)**: Practice guideline for the pharmacological treatment of patients with alcohol use disorder (2018)
- **American Society of Addiction Medicine (ASAM) and American Academy of Addiction Psychiatry (AAAP)**: Clinical practice guideline on the management of stimulant use disorder (2024)
- **American Society of Addiction Medicine (ASAM)**: National practice guideline for the treatment of opioid use disorder (2020)
- **American Society of Addiction Medicine (ASAM)**: Clinical considerations: Buprenorphine treatment of opioid use disorder for individuals using high-potency synthetic opioids (2023)
- **The Department of Veterans Affairs (VA) and the Department of Defense (DoD)**: Clinical practice guideline for the management of Major Depressive Disorder (MDD) (2022)
- **American Academy of Child &Adolescent Psychiatry (AACAP)**: Clinical practice Guideline for the Assessment and Treatment of Children and Adolescents With Major and Persistent Depressive Disorders (2023)

Note: These guidelines are not decisions for coverage, benefits determinations or treatments.

More information

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

2026 Aetna® behavioral health quality management program summary

Read about what we've achieved and what's on the horizon.

Quality management and improvement efforts

We work hard to improve the service, quality and safety of our health care. Learn about our efforts and how far we've come.

Behavioral health initiatives

Enhancing health and mental well-being can improve people's lives. Our quality management program continually monitors the behavioral health (BH) care we provide to our members.

Highlights from 2025

- Achieved 99.38% score (100% for all standards owned by BH Accreditation Team) on National NCQA MBHO re-accreditation survey.
- Coordinated updates to our Participation Criteria Manual (for practitioners and facilities) which removed confusing information and clarified our appointment timeliness requirements.
- Successfully closed a gap related to commercial member complaints routing.
- The Suicide Prevention team fulfilled their five-year commitment to reduce suicide attempts among the commercial adult population. As of July 2025, there was a 26% reduction in suicide attempts among individuals aged 26 and older. This surpassed the original goal of 20%.
- The MinuteClinic® team partnered with the Aetna BH Product team to continue to optimize Aetna Health search and visibility in the provider directory, ensuring that MinuteClinic® BH providers can better engage our members.

Plans for 2026

- Expand our network to improve the availability of BH providers and patient wait times.
- Continue to survey our members and caregivers who have completed our BH case management program.
- Improve the timeliness of the recredentialing cycle for BH practitioners.

- Develop the ability to schedule appointments with individual MinuteClinic® clinicians through our secure member website.
- Continue to develop tech innovations to streamline work and improve member experience overall.
- Develop a population health management strategy which will identify goals to improve member wellbeing and outcomes.
- Continue working to improve quality of care, clinical outcomes and patient safety.
- Promote **care coordination** between medical and BH providers.

More information

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

Depression in primary care program

Our program can help you screen and treat depression at the primary care level. Find out how to get started.

Our depression in primary care program supports early identification and follow-up for depression in the primary care setting. The program reimburses participating in-network providers for using validated screening and monitoring tools for our members with medical benefits. Common tools include the Patient Health Questionnaire, such as the PHQ-2 and PHQ-9.

What to bill

Bill each screen using the most appropriate diagnosis and procedure code combination. Diagnosis codes include the following:

- Z13.31 for depression screening
- Z13.32 for maternal depression screening
- Z13.39 for other mental health and behavioral disorder screening

Procedure codes include: 96127, 96160, 96161 and G0444 for annual depression screening.

How to submit

Submit claims through your normal claims process using the appropriate diagnosis and procedure codes for the screening performed. The treating provider should determine when to screen and how often to repeat screening based on the patient's condition, clinical judgment, current guidelines and best practices.

More information

For more information about the program, including validated screening tools and provider resources, visit **Aetna.com**.

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

Use Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care

The Institute of Medicine encourages you to use the SBIRT model, and we'll reimburse you if you do.

The SBIRT program supports primary care providers in screening patients for risky alcohol or substance use, offering a brief intervention and referring patients for treatment when needed. The program follows an evidence-based approach from the Substance Abuse and Mental Health Services Administration (SAMSHA) and is available for our members with medical benefits. Initial screening and brief intervention are reimbursable services, except for capitated membership, where they're included in capitation.

Tools and screenings

You can use standardized tools, such as the Alcohol Use Disorders Identification Test and the Drug Abuse Screening Test, to identify patients who may need support. If the screening shows risk, you can offer a brief intervention and, when appropriate, refer the patient for additional treatment. The treating provider should decide when to screen and how often to repeat screening based on clinical judgment, current practice guidelines and the patient's needs.

Billing and submission

The primary care physician's office can bill for each screen by submitting the appropriate code:

- 99408: Alcohol and/or substance abuse structured screening and brief intervention services, 15 to 30 minutes
- 99409: Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes
- G0396: Alcohol and/or substance abuse structured assessment and brief intervention, 15 to 30 minutes
- G0397: Alcohol and/or substance abuse structured assessment and intervention, greater than 30 minutes
- G0442: Annual alcohol misuse screening, 5 to 15 minutes

- G0443: Brief face-to-face counseling for alcohol misuse

More information

Submit claims using standard billing processes and include the appropriate code based on the service provided and time spent. You should continue to verify patient eligibility and benefits before delivering services. For more information about the SBIRT program, visit our provider resources on **Aetna.com**.

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

Medicare

Get Medicare-related information, reminders and guidelines.

Compression stockings and foot orthotics: Coverage highlights

Read more about coverage exclusions and when stockings are medically necessary.

Compression stockings and foot orthotics can often help manage leg swelling, venous conditions and mobility challenges. Many group employer plan sponsors include additional coverage for their retirees, often at a $0 copay. Some plans may allow unlimited single items or pairs each year. Because coverage varies by plan, you're encouraged to verify patient benefits in advance to confirm eligibility through our **provider portal on Availity**.*

Understanding coverage basics and accurate documentation helps support smoother authorizations, correct billing, faster payment and fewer claim denials — ultimately helping you get paid accurately and on time.

When compression stockings are medically necessary

We consider medical-grade compression stockings (greater than 18 mm Hg) medically necessary for patients with qualifying conditions, including:

- Complications of chronic venous insufficiency
- Lymphedema
- Post-thrombotic (post-phlebitic) syndrome
- Edema following surgery, injury, burns or trauma
- Edema related to paraplegia or quadriplegia
- Prevention of blood clots in immobile patients

- Post-sclerotherapy care

Custom vs. pre-made stockings

- Pre-made medical-grade stockings are typically required first
- Custom-made stockings may be covered when:
    - A three-month trial of pre-made stockings has failed
    - The patient cannot be properly fitted
    - The patient has venous ulcers or lymphedema (trial not required)

Coverage exclusions

Compression garments aren't covered for experimental or unsupported uses, such as athletic recovery, muscle soreness, Parkinson's disease or conditions related to Long COVID-19.

Foot orthotics

Foot orthotics may complement compression therapy by improving alignment, reducing pressure and supporting mobility. Covered conditions may include plantar fasciitis, foot deformities, diabetes-related foot conditions, nerve or circulation issues and certain pediatric gait concerns.

More information

For complete coverage details, refer to Clinical Policy Bulletins 0451 and 0482 on **Aetna.com**.

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Complete your required Medicare compliance training and attestation by October 31, 2026

You received an email via Adobe Acrobat Sign reminding you of the annual training and attestation as required by the Centers for Medicare & Medicaid Services (CMS). If we don't have your compliance email address, you received a postcard reminder.

If you're participating in our Medicare Advantage (MA) plans, you must meet CMS compliance requirements for first-tier, downstream and related entities (FDR). If you're caring for Special Needs Plan (SNPs) members, you must also complete your annual Model of Care (MOC) training.

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

How to submit your attestation

Visit the **Medicare compliance and attestation** page to review the training materials and submit your attestation by October 31, 2026, to remain compliant.

Why NPPES accuracy matters

CMS will defer to NPPES data, not plan-submitted data, when there is a discrepancy between the two.

To improve provider data accuracy, the Centers for Medicare & Medicaid Services (CMS) stresses the importance of the **National Plan and Provider Enumeration System (NPPES)** as a key source of provider demographic information used across Medicare systems, including the **Medicare Plan Finder (MPF)**.

CMS continues to advance provider directory accuracy initiatives, including development of a National Provider Directory and future requirements under the **REAL Health Providers Act**.

What else to know

While requirements vary, maintaining accurate NPPES data will remain foundational across Medicare programs.

- Beginning October 1, 2026, MPF will display provider directory data for Contract Year 2027.
- If there is a difference between plan-submitted data and NPPES data, CMS will use NPPES data to populate provider information in MPF.
- Outdated information in NPPES could override more current plan data, resulting in:
    - An inaccurate public display of your location, contact details or specialty
    - Fewer Medicare beneficiaries finding and selecting your practice

What to do

Review and update your NPPES information before October 1, 2026. Also be sure to enter any change to your information **within 30 days of the change**.

Find out more about NPIs and NPPES.

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