June 2025

OfficeLink Updates™

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

HIGHLIGHTS IN THIS ISSUE

ASR Health Benefits, an Aetna Signature Administrators® (ASA) third-party administrator, adds members

On January 1, 2025, ASR Health members started to use the ASA preferred provider organization program and medical network outside of Michigan.

How to properly submit lab results using Epic Payer Platform

Sometimes we don't receive the clinical data we need for reimbursement programs such as Healthcare Effectiveness and Data Information Set (HEDIS®) quality measures.

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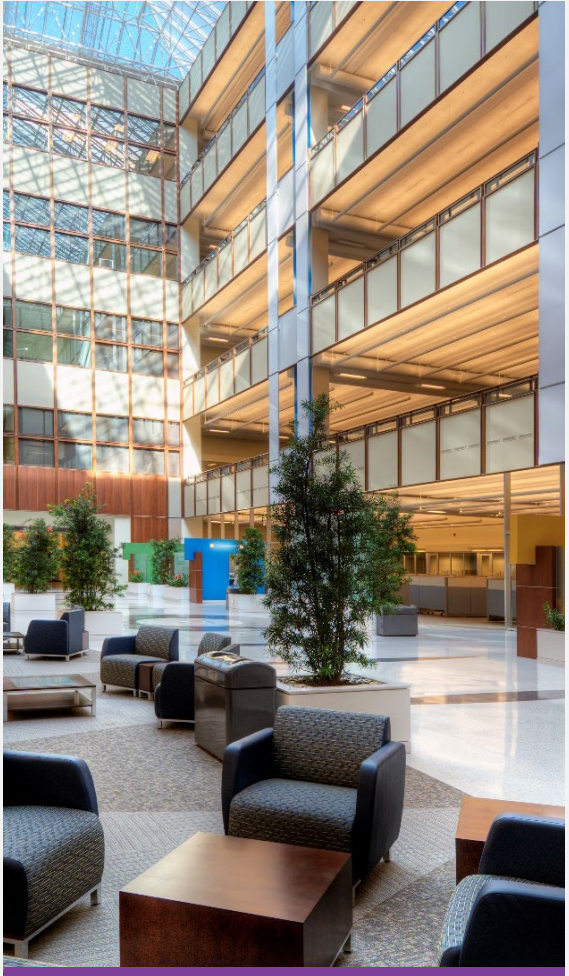

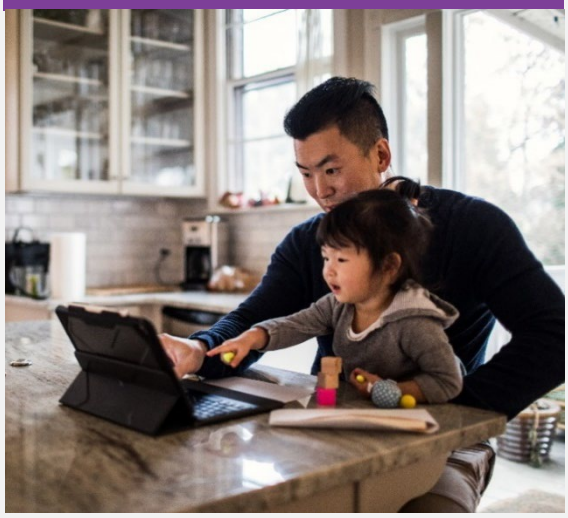

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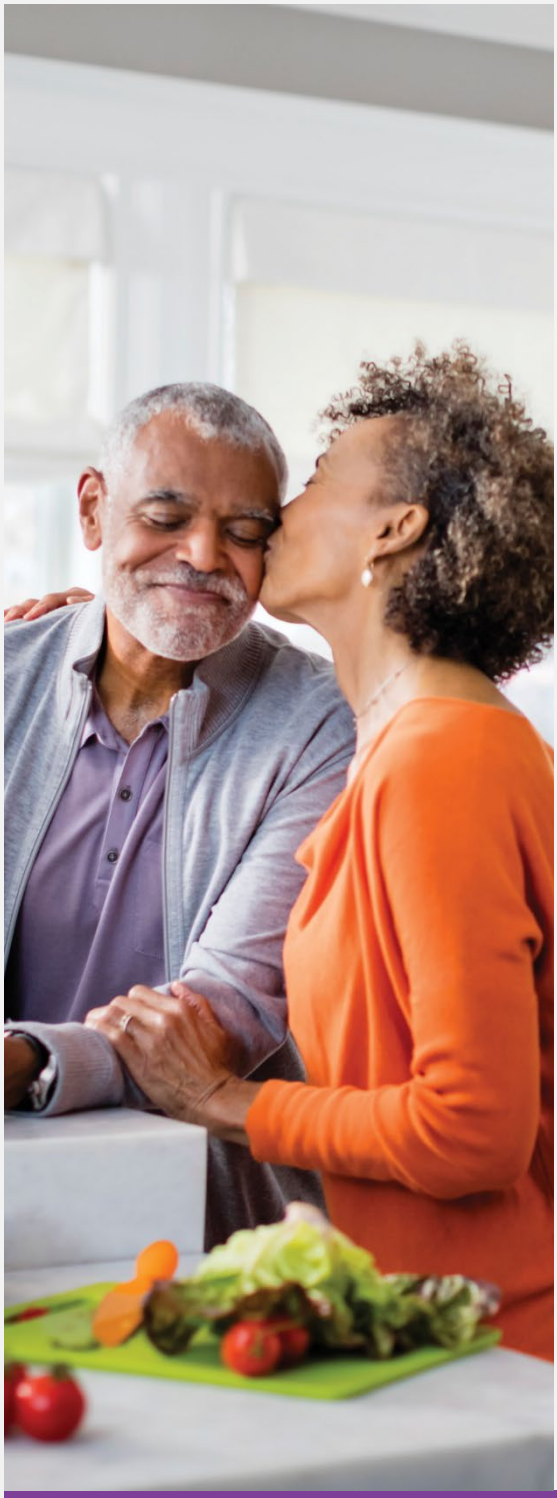

Important policy updates (including pharmacy)

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 September 1, you'll see new claim edits.

This update will apply to both our commercial and Medicare members.

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

For coding changes, go to Aetna Payer 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.

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

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.

Changes to commercial drug lists begin on October 1

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

On October 1, 2025, 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 August 1, 2025. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug PA

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

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

More information

For more information, refer to the **Contact Aetna** page. Select the Providers tab. In the "Call us" column, choose "Special programs" from the drop-down menu and use the "Pharmacy management" number.

Important pharmacy updates

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

Medicare

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

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

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

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

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

Student Health

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

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

Aetna federal employee plans

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

State-specific updates

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

Updates to official notice addresses for contract termination notification

New addresses are effective immediately.

Note: This article applies to the following states: Arizona, California, Colorado, Kansas, Maine, Michigan, Nebraska, Nevada, New Jersey, Texas, Utah, Virginia and Washington.

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

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

Arizona address

Old address:	Chandler, AZ 1255 S Spectrum Blvd
New address:	Network Management PO Box 818001 Cleveland, OH 44181-8001

California addresses

Old address:	Woodland Hills, CA 21255 Burbank Blvd
New address:	Network Management P.O. Box 818090 Cleveland, OH 44181-8090
Old address:	Fresno, CA 1385 East Shaw Ave
New address:	Network Management P.O. Box 818012 Cleveland, OH 44181-8012
Old address:	Concord, CA 1401 Willow Pass Rd
New address:	Network Management P.O. Box 818024 Cleveland, OH 44181-8024

Colorado address

Old address: Denver, 54582 S. Ulster St.
New address: Network Management
P.O. Box 818024 Cleveland, OH 44181-8024

Kansas address

Old address: Overland Park, 9401 Indian Creek
New address: Network Management
P.O. Box 818045 Cleveland, OH 44181-8045

Maine address

Old address: Portland, 191 Marginal Way
New address: Network Management
P.O. Box 818048 Cleveland, OH 44181-8048

Michigan addresses

Old address: Lansing, 1044 Eastbury Drive
New address: Network Management
P.O. Box 818030 Cleveland, OH 44181-8030

Old address: South Field, 28588 Northwestern Hwy
New address: Network Management
P.O. Box 818030 Cleveland, OH 44181-8030

Nebraska address

Old address: Omaha, NE 11819 Main St
New address: Network Management
P.O. Box 818038 Cleveland, OH 44181-8038

Nevada address

Old address: Las Vegas, 1140 N. Town Center Drive Suite 190
New address: Network Management
P.O. Box 818087 Cleveland, OH 44181-8087

New Jersey address

Old address: Princeton, 3 Independence Way
New address: Network Management
P.O. Box 818003 Cleveland, OH 44181-8003

Texas address

Old address:	Houston, 14955 Heathrow Forest
New address:	Network Management P.O. Box 818026 Cleveland, OH 44181-8026

Utah address

Old address:	Sandy, UT 10150 South Centennial Pkwy
New address:	Network Management P.O. Box 818087 Cleveland, OH 44181-8087

Virginia address

Old address:	Richmond, VA 9881 Maryland Dr
New address:	Network Management P.O. Box 818044 Cleveland, OH 44181-8044

Washington address

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

Changes to Enhanced Clinical Review program

Radiation therapy and oncology procedures will now require prior authorization (PA) with CVS Health Solutions.

Note: This article applies to the following states: Arizona, Connecticut, Illinois, Pennsylvania and Texas.

This update applies to Aetna® Medicare Advantage products in Arizona, Connecticut, Illinois, Pennsylvania and Texas.

This update doesn't apply to Aetna commercial products in Connecticut, Illinois, Pennsylvania and Texas and will continue to be handled by EviCore healthcare.

Beginning August 1, 2025, our Enhanced Clinical Review program, which currently requires PA for radiation therapy/radiation oncology procedures with EviCore healthcare, will now require PA with CVS Health Solutions.

Services that require pre-approval:

- 77014, 77371, 77372, 77373, 77385, 77386, 77387, 77401, 77402, 77407, 77412, 77423, 77424, 77425, 77520, 77522, 77523, 77525, 77600, 77605, 77610, 77615, 77620, 77750, 77761, 77762, 77763, 77767, 77768, 77770, 77771, 77772, 77778, 79005, 79101, 79403
- A9513, A9543, A9606, A9590
- G0339, G0340, G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016, G6017
- 0394T, 0395T, 0747T

For a complete list of procedures that need authorization, please go to our **Precertification Lists** page. To review our Clinical Policy Bulletins, go to our **Clinical Policy Bulletins** page.

Submitting authorization requests

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

If a date of service is on or after August 1, 2025, and you haven't already requested precertification, contact CVS Health Solutions to request authorization. There are three ways you can do this:

- Log in to our **provider portal on Availity*** and navigate to Novologix®.
- Call **1-866-231-8569 (TTY: 711)** during normal business hours.
- Send an **email message**.

Urgent requests

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

Tips

- We recommend that ordering physicians get authorizations and share the approval numbers with the facility performing the procedure when that procedure is scheduled.
- Approvals have both authorization numbers and CPT® codes specific to the approved services.**
- If you perform services without approval, we may deny payment. Please don't ask members for payment, as outlined in your agreement with us.
- We'll determine coverage under the applicable policy in accordance with the policy's terms and conditions and with our policies and procedures.

Questions?

Refer to our **Contact Aetna** page. To find out about our radiation oncology criteria, go to our **Cancer Care Management** page.

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Arizona: Your APS patients are in the Aetna® network

View our Banner|Aetna sample ID cards below.

In January, Arizona Public Service (APS), the largest electric utility in Arizona, transitioned their medical plans to Banner|Aetna. *If you're a contracted Aetna provider, you participate in these plans.*

Always check eligibility

The Banner|Aetna plans use the Aetna® BROAD, Choice POS II network, as indicated on the lower right side of the ID card (see the sample below). Always check eligibility via our provider portal on Availity® or other verification systems.*

More information

You can contact Aetna by going to **Aetna.com/health-care-professionals.html**. Choose "Contact Us" and then select the "Providers" tab.

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California: How to meet the linguistic needs of Individual & Family Plan (IFP) members

Fee-for-service providers: Learn about your patients' language preferences.

We're committed to providing equitable, high-quality health care. To help reduce health disparities and promote health equity, we collect member language preferences.

We can provide you with a patient's language preference, if you ask for it, when you call the Provider Contact Center (PCC) at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** to verify eligibility.

A member's preferred language is not currently visible on our **provider portal on Availity**.* Please call the PCC for this information to help you to anticipate the language needs of your patients.

Call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly.

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California: Access standards

These standards cover appointment availability, exceptions to appointment time frames and criteria for rescheduling.

California law has established appointment availability standards to ensure timely access to necessary health care services. Our members have the right to schedule an appointment within the following time frames:

Appointment type	**Time frame**
Urgent care services that don't require prior authorization	48 hours from request
Urgent care services that require prior authorization	96 hours from request
Non-urgent doctor appointment (primary care physician)	10 business days
Non-urgent doctor appointment (specialty physician)	15 business days
Non-urgent mental health appointment (non-physician)	10 business days
Non-urgent appointment (ancillary provider)	15 business days
Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider	10 business days for those undergoing a course of treatment for an ongoing mental health

	or substance use disorder condition

Note: A referral to a specialist by a primary care provider or another specialist is subject to the relevant time-elapsed standards listed above.

Exceptions to the above appointment time frames

- The above time frames may be extended if the referring or treating provider determines and notes in the appropriate record that a longer wait time won't have a negative impact on the member's health.
- Preventive care services and follow-up care may be scheduled in advance as determined by the treating licensed health care provider.

Rescheduling appointments

If it's necessary for you or a member to reschedule an appointment, the appointment must be promptly rescheduled in a manner that's appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice.

We don't delegate monitoring and assessment of these standards to any of our contracted provider groups. We'll assess our contracted provider network against these standards by conducting an annual provider survey to assess appointment availability and a provider satisfaction survey to solicit concerns and perspectives.

California: 2025 Provider Appointment Availability Survey (PAAS)

We might contact your office with our brief survey questions, and we're required to send your responses to the DMHC and the CDI.

California law requires that health plans survey their network providers annually to ensure that they comply with California time-elapsed standards for urgent and non-urgent appointments.

We've contracted with the Center for the Study of Services (CSS) to administer the PAAS for 2025. We'll assess compliance through the PAAS and report the results to the California Department of Managed Health Care (DMHC) and to the California Department of Insurance (CDI).

Your office may be contacted via fax, email or phone for the purposes of this assessment. This survey should take only a few minutes of your time and will be conducted during normal business hours. We appreciate your cooperation in complying with this regulation.

Providers to be surveyed

- Primary care physicians (PCPs)
- Specialty physicians
- Psychiatrists
- Non-Physician Mental Health (NPMH) providers and Substance Use Disorder (SUD) providers
- Ancillary providers who offer mammogram appointments and ancillary providers who offer physical therapy appointments

Survey questions

- Urgent appointments: Is the appointment date and time within 48 hours (for a PCP visit request) or within 96 hours (for a specialist/psychiatrist/NPMH or SUD visit request)?
- Non-urgent appointments: Is the appointment date and time within 10 business days (for a PCP/NPMH visit request or a SUD visit request) or within 15 business days (for a specialist/psychiatrist/ancillary visit request)?

Note that both in-person visits and telehealth visits qualify as appointments.

The importance of your response

Because you're a contracted provider, we encourage you to make every effort to respond to the survey. Your response should accurately reflect your appointment availability for our members.

We'll report all responses, including non-responses, to the DMHC. If your office doesn't respond to the survey, we might issue a corrective action plan.

California: Make member grievance forms available at your office

You can get these forms, which allow members to file grievances with numerous entities, in English or Spanish.

California regulations require you to make **member grievance forms** for health plans available at all office or facility locations.

Our members may file a grievance with us, the California Department of Managed Health Care (DMHC), or the California Department of Insurance (CDI) for any reason, including delays in timely access to care or timely referrals.

You can download the California HMO and California DMO grievance forms, which include information about member rights and responsibilities, in English and Spanish.

California: Use our interpretation service at no cost

This program is for both providers and members, and our hotlines and help centers can provide translations of important medical documents.

Need help giving care to non-English-speaking Aetna® members? Just use our Language Assistance Program (LAP). There's no charge for this interpretation service.

You can call **1-800-525-3148 (TTY: 711)** to reach a qualified interpreter directly.

Members can also request interpretation services from our LAP by calling the number on their ID card. They can contact our LAP for general questions, to file a grievance or to get a grievance form.

Questions?

Get help from your state. Just call the:

- **CA Department of Insurance** Hotline at **1-800-927-4357** for traditional plans
- CA Department of Managed Health Care Help Center at **1-888-466-2219 (TDD: 1-877-688-9891)** for HMO and DMO plans

You can reach the **California Department of Managed Care Help Center** 24/7. The department's internet web site is **www.dmhc.ca.gov**. It provides written translation of independent medical review and complaint forms in Spanish and Chinese and other languages. You can get paper copies of the forms by submitting a written request to:

California Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Or, for traditional plans, the **California Department of Insurance** at:
https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

Illinois: Help us comply with a law about how we communicate contractual changes

We need to collect and store a current email address for you or an authorized staff member.

Illinois law requires us to tell you about nonroutine changes to contractual fee schedules via email. As a result, we need to collect and store a current email address for you or your staff member who is authorized to receive this information.

How to give us a current email address

If you use our **provider portal on Availity**,* follow these steps:

- Log in to Availity®.
- Go to My Providers > Provider Data Management (user must have access and be listed as Key Staff by their office Availity Administrator).
- Select Business/Provider to update > select Key Staff name.
- Complete the Key Staff information, including email address.
- Choose Save.

We appreciate your help

Thank you for giving us your current email address to assist us in complying with this new law. If you have any questions on how to provide or update your email address with us or if you would like more information on why we need it, visit our **Contact Aetna** page.

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Maryland: Proper coding for preventive care

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

The Department of Labor, the Department of Health and Human Services, and the Department of the Treasury, in accordance with the **Patient Protection and Affordable Care Act (ACA) and the Women's Health and Cancer Rights Act Implementation part 68**, have asked us to remind you to use correct service codes and modifiers.

You should regularly review resources from the United States Preventive Services Task Force (USPSTF) to ensure that patients are not charged cost-sharing amounts for recommended preventive items and services.

The importance of proper coding

Please adhere to industry-standard coding practices that clearly distinguish preventive services from diagnostic, therapeutic or other non-preventive services. The departments listed above consider the following resources to be reliable:

- 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 are entitled to.

Modifier 33

You can use modifier 33 to:

- Indicate that a service is an evidence-based service in accordance with the guidelines provided by one of the ACA-designated organizations, including an A or B recommendation from the USPSTF or recommendations from the Advisory Committee on Immunization Practices or Health Resources and Services Administration. Evidence-based services must be covered without cost sharing.
- Identify a service that may or may not be preventive depending on the circumstances.

Codes with a "Z" prefix

The International Classification of Diseases, 10th revision (ICD-10), includes codes with the prefix "Z" to indicate an encounter for preventive purposes.

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New York: Credentialing requirement for individual psychoanalysts

A state regulation requires that we credential all individual psychoanalysts in the state of New York except those who are hospital-based or delegated. We'll discontinue any individual psychoanalyst you send to us for credentialing for a state other than New York.

What to know

If you're a new individual psychoanalyst in New York state, you'll need to go through the **provider onboarding** process and complete a Council for Affordable Quality Healthcare (CAQH) application.

New York: Annual validation of your demographic information

You're obligated to keep your information updated.

New York law requires that we annually validate the information that appears in our provider directories. Your contract with us obligates you (whether an individual provider or a facility) to share changes in information, which include changes to name, address, telephone number and digital contact information.

To help us ensure that we have your most up-to-date information, you can:

- Use our **provider portal on Availity*** to update your information (if you're already registered with Availity® for another payer, you can use your existing log-in credentials to get started with us).
- Go to the **Stay Up to Date** page on **Aetna.com**.
- Go to our **provider site** and choose "Contact us."

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North Carolina (NC) State Health Plan changes for 2026

Keep up to date on **NC State Health plan** information.

To stay informed and keep in touch with us, sign up for **email communications**.

Questions?

Contact Aetna Network Management staff or call us at **1-800-353-1232 (TTY: 711)** during normal business hours.

We look forward to partnering with you to continue to serve NC State Health Plan members.

Virginia: Help us comply with a law about how we communicate contractual changes

We need to collect and store a current email address for you or an authorized staff member.

Virginia law requires use of electronic communications for contract-related matters. As a result, we need to collect and store a current email address for you or a staff member who is authorized to receive this information.

How to give us a current email address

If you use our **provider portal on Availity**,* follow these steps:

1. Log into Availity®.
2. Go to My Providers > Provider Data Management (user must have access and be listed as Key Staff by their office Availity Administrator).
3. Select Business/Provider to update > select Key Staff name.
4. Complete the Key Staff information, including email address.
5. Choose Save.

We appreciate your help

Thank you for giving us an address. If you have any questions about how to provide or update your email address or if you would like more information on why we need it, visit our **Contact Aetna** page to find out how to reach us.

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News for you

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

Update your provider data to help make cultural competency and health equity a priority

Help us ensure equitable access to care.

Understanding the importance of cultural competency and health equity in health care can help improve your patients' overall health care experience and drive positive health outcomes. The Centers for Medicare & Medicaid Services (CMS), National Committee for

Quality Assurance (NCQA) and/or state regulators are also making cultural competency and health equity a required priority.

To ensure equitable access to care, health plans are being asked to collect and display your race, ethnicity, language and cultural competency information.

Individual providers

Please take a moment to complete our **new requirements individual provider information form.** We'll publish this information in our provider directories (commercial, Medicare and Medicaid, if applicable). Select the **individual provider form** to submit updates for multiple providers.

You can watch this **Cultural competency training video** to learn more about cultural competence and the key role you play as a provider. Visit **CVS Health's Health Equity Clinical Education Hub** to access free online educational resources and earn digital badges for display in our directories. We will receive your course completion electronically, via a monthly file, and we will display your digital cultural competency badge(s) in our provider directories.

Hospitals and other facility type providers

If you're a hospital managed care office or a free-standing facility, please complete our **new requirements hospital/facility information form**. This information will be published in our provider directories (commercial, Medicare and Medicaid, if applicable). Select the **facility form** to submit updates for multiple facilities.

What happens if you're contracted with Aetna Better Health (ABH) (Medicaid, Medicare-Medicaid plans)?

On the data submission form we ask if the provider or facility is contracted with ABH (Medicaid, Medicare-Medicaid plans). If so, use the above individual and/or hospital/facility form links to verify that we should update our separate ABH system with this added information.

Check your Aetna Premier Care Network (APCN) status for 2026

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

Now is a good time to check our **online provider referral directory** to see if you're participating in our Aetna Premier Care Network APCN/APCN Plus programs for 2026. If you have questions, visit our **Contact Aetna** page.

Notable 2026 APCN changes

- Odessa, Texas: High Performance Network Market withdrawal

Notable 2026 APCN Plus changes

- Odessa, Texas: High Performance Network Market withdrawal
- Maine: Aetna Whole Health℠ network withdrawal

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 (ACO) and joint ventures (JV) in certain areas. Members in these networks will have APCN Plus and the name of the ACO/JV on their ID card for identification.

Costco Wholesale plans and PCPs

We'll add a PCP name to member ID cards, but members can visit any PCP.

As of January 1, 2025, Costco Wholesale plans started to use the Aetna® PCP Choice feature. This means we'll add the name of a local PCP to the member's ID card.

Costco plans don't require members to use the PCP listed on the ID card. We implemented PCP Choice to encourage Costco employees and their family members to establish a relationship with a PCP to improve access to preventive and primary care.

The plan's PCP copay is the same regardless of whether the member visits the PCP listed on the ID card or any other network PCP.

Please don't turn members away if you're not listed as the PCP on the card. The plan will still pay.

If you have any questions, go to the **Contact Aetna** page. In the "Call us" column, choose Aetna service centers from the drop-down menu and dial **1-888-632-3862** **(TTY: 711)**.

Important update about service codes

Individual service codes are being reassigned within existing contract service groups. An individual provider's compensation depends on the presence or absence of specific service groupings in their contract. These changes are shown below.

CPT® codes*	Provider types affected	What's changing
33340, 93590, 93591, 93592	Facilities, including acute short-term hospitals	Will be **added** to the Cardiac Catheterization Procedures Contract Service Grouping.

HCPC codes	Provider types affected	What's changing
A9513, J0185, J0517, J0567, J0584, J0599, J0841, J1301, J1454, J1627, J1628, J1746, J2062, J2797, J3245, J3304, J3316, J3397, J3398, J7170, J7177, J7203, J7296, J7318, J7329	Facilities, including acute short-term hospitals	Will be **added** to the Chemotherapy & All Other Drugs Contract Service Grouping.

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Proper coding for preventive care

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

The Department of Labor, the Department of Health and Human Services, and the Department of the Treasury, in accordance with the **Patient Protection and Affordable Care Act (ACA) and the Women's Health and Cancer Rights Act Implementation part 68**, have asked us to remind you to use correct service codes and modifiers.

You should regularly review resources from the United States Preventive Services Task Force (USPSTF) to ensure that patients are not charged cost-sharing amounts for recommended preventive items and services.

The importance of proper coding

Please adhere to industry-standard coding practices that clearly distinguish preventive services from diagnostic, therapeutic or other non-preventive services. The departments listed above consider the following resources to be reliable:

- 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 are entitled to.

Modifier 33

You can use modifier 33 to:

- Indicate that a service is an evidence-based service in accordance with the guidelines provided by one of the ACA-designated organizations, including an A or B recommendation from the USPSTF or recommendations from the Advisory Committee on Immunization Practices or Health Resources and Services Administration. Evidence-based services must be covered without cost sharing.
- Identify a service that may or may not be preventive depending on the circumstances.

Codes with a "Z" prefix

The International Classification of Diseases, 10th revision (ICD-10), includes codes with the prefix "Z" to indicate an encounter for preventive purposes.

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ASR Health Benefits, an Aetna Signature Administrators® (ASA) third-party administrator adds members

Earlier this year, 3,000 members were added to the medical network outside of the state of Michigan.

On January 1, 2025, ASR Health members started to use the ASA preferred provider organization program and medical network outside of Michigan.

How to check eligibility and get additional support

To check eligibility or verify benefits for ASR Health members, refer to the ASR Health provider service phone number on the member's ID card or visit **their online page**.

How to send claims

Our TPA partners handle all claims processing and claims questions. Send claims electronically to ASR Health Benefits EDI ID #38265. You'll also find this number on the member's ID card.

Or send paper claims to:

ASR Health Benefits
P.O. Box 6392
Grand Rapids, MI 49516-6392

If an ASA member uses a transplant facility in our Institutes of Excellence™ program, the facility will use the Special Case Customer Service Unit for submitting claims.

Please note that neither Aetna® nor ASA can verify eligibility or process claims.

More information

To learn more, see our **ASA Flyer (PDF)**.

How to avoid denials on commercial claims by checking your claim status

You can find the EOB statement via Availity® or your clearinghouse.

Sometimes we need additional information to process your claim. When this happens, we put it in a pending status. The remarks on the claim's Explanation of Benefits (EOB) statement tells you what we need, how to send it and the submission deadline.

How to find the EOB statement

On our **provider portal on Availity**:*

1. Submit a claim status inquiry (CSI) transaction to locate the claim.
2. Download the EOB statement using the Availity Remittance Viewer. You'll find it at the top of the page.
3. Read the remark message and gather the requested documentation.

4. Rather than mail or fax, upload using the “Send attachments” button. Be sure to include a copy of the EOB statement. This helps us route everything to the correct department.

Via a clearinghouse:

- We respond to your electronic claim submission with a Claim Acknowledgement transaction, the 277CA. It’s sent to your clearinghouse. This transaction will alert you if the entire claim was accepted or rejected. For an accepted claim, we’ll provide the assigned claim number, which you can use to check the status.
- If we pend your claim, we’ll send a pended claims report — the Claim Pending Status report (277P) transaction — to your clearinghouse.
- Using the 277P, read the remark message on the EOB statement and respond. Be sure to include a copy of the EOB statement. This helps us route everything to the correct department.

Contact your clearinghouse if you don’t know how to find your pended claims. If your clearinghouse doesn’t provide pended claims, you can use our provider portal on Availity.

What happens if we don’t hear from you

If we don’t receive the requested information by the deadline, the claim won’t process and may result in a denial.

Where to go for help

If you have any questions, you can contact Availity at **1-800-AVAILITY** **(1-800-282-4548)** or your clearinghouse.

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

How to properly submit lab results using Epic Payer Platform

Use the Encounter Conversion function to convert appointments to the correct encounter type.

The information in this article applies to you if all of the following apply:

- You use Epic EHR version February 2022 or later. You can find out which version you have by checking the Affected Versions table.
- You use Epic Payer Platform as a provider organization.
- You are not converting lab visit types to the appropriate Epic encounter type so that they can be shared with external organizations.

The problem

Sometimes we don't receive the clinical data we need for reimbursement programs such as Healthcare Effectiveness and Data Information Set (HEDIS®) quality measures. This is because your Epic Electronic Health Records (EHR) system might not be converting lab draw appointments to the correct Epic encounter type.

If you don't convert those appointments to the correct encounter type, we won't receive the visit or the lab results via Epic Payer Platform. We cannot accept the missing data via any other method.

What you need to do

Epic will not be releasing a Special Update (SU) to solve this problem. Therefore, you should update your configuration so that all visit types, including lab visits, are converted to a non-appointment encounter type.

You should have received a **Financial Risk Escalation (FRE)** in the monthly Epic Financial Bulletin on March 17. The FRE is also viewable on the Epic UserWeb Sherlock site, in the Reportable Issues tab.

Use these steps:

1. Review the Reportable Issue (**Q-7841810**).
2. Follow Epic's guidance to assess current build and configuration.
3. Make changes to your configuration, if needed.
4. Run the **Encounter Conversion Utility** in your PRD environment.
5. Epic recommends that you tell payers to start their backfills to retrieve lab encounters.

You can also refer to the **Determine How Encounters Are Converted topic** on the Epic UserWeb for detailed configuration instructions.

Help improve communication between treating providers

Use our forms to make it easier to communicate with other practitioners.

Based on the results of a recent survey, we know that primary care physicians (PCPs) are concerned about how they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.
This breakdown in communication can pose a threat to quality patient care. We understand that coordinating care with many physicians, facilities and behavioral health care professionals can be a challenge.

Use our tools to share information

Comprehensive patient care includes communicating with your patients' other treating health care professionals. To promote collaboration and comprehensive care, it's critical that PCPs and specialists talk openly with each other.

You can use **our forms and applications** to help.

Thank you for your efforts to improve how you communicate with other providers.

Behavioral health

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

Follow-up care for ADHD

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

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

One measure that we monitor is the HEDIS ADD 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 during the 9 months after the initiation phase in addition to receiving two additional follow-up visits within those 9 months).

Best practices

The **American Academy of Pediatrics** and the **American Academy of Child & Adolescent Psychiatry** provide recommendations for best practices when treating ADHD. Some recommendations include:

- Explaining medication options and side effects
- Discussing behavioral therapy, psychotherapy, family therapy, support groups, social skills training and/or parenting skills
- Scheduling a follow-up visit for 30 days after the initial prescription

- Scheduling monthly visits, if needed, until a good routine is in place, then every 3 months for the first year
- Collaborating with other medical providers and the school

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

Behavioral health clinical criteria

Read about how we determine coverage and where to go for more information.

How we determine coverage

Our medical directors make all coverage denial decisions based on behavioral health clinical criteria. Only our medical directors, psychologists, board-certified behavior analysts-doctoral (BCBA-D) and pharmacists make denial decisions for reasons related to medical necessity. (Licensed pharmacists and psychologists review coverage requests as permitted by state regulations.)

Where state law mandates, utilization review coverage denials are made, as applicable, by a physician or pharmacist licensed to practice in that state.

Behavioral health staff use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning and retrospective review. Staff use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition:

More information about our behavioral health clinical criteria

- **Aetna clinical policy bulletins**
- **Guidelines for coverage determination**
- **Centers for Medicare & Medicaid Services (CMS):**
  - National Coverage Determinations (in the blue box at the top of the page)
  - Local Coverage Determinations (under Coverage Process)
  - Medicare Benefit Policy Manual (under Related Instructions)
- **The American Society of Addiction Medicine (ASAM) Criteria**: textbook, third edition (applies only to our commercial line of business starting on January 1, 2024. The ASAM criteria content is copyrighted. Contact the **American Society of Addiction Medicine** for information on how to purchase it.
  - Substance use disorder care in New York state: **Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)**
  - **LOCUS© and CALOCUS-CASII©**
  - **CMS Medicare Prescription Drug Benefit Manual**
  - **CMS Medicare Managed Care Manual**

States may also mandate the use of other criteria and guidelines.

Hard copies

Need hard copies of a specific criteria for a specific determination? We're here to help. Visit our **Contact Aetna** page.

Medicare

Get Medicare-related information, reminders and guidelines.

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

We require participating providers in our Medicare Advantage (MA) plans to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related entities (FDR) as outlined in the trainings below.

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

2025 direct provider notification

In 2025, participating providers will receive a training and attestation notice to the compliance email(s) identified in their 2024 attestation. If we don't have your email address (or the email is returned), you will receive a postcard reminding you to complete your attestation (and MOC training, if applicable). If you prefer, review the trainings, and complete your attestation now.

Our training materials

Review the training(s) and complete your attestation by visiting the **Medicare compliance and attestation page.**

Trainings:

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

Attestations based on contracted plans:

Providers:

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

Delegates:

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

Where to get more information

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

We submitted the 2025 HEDIS® medical record collection project results

We're working to close data and care gaps for an enhanced provider and patient experience.

Annually, we collect HEDIS* (Healthcare Effectiveness Data and Information Set) data from claims, encounters, administrative data and medical records. We support a consumer-obsessed culture—one that enhances member health and quality of life, expands provider relationships to support an enhanced patient experience and closes data and care gaps.

We submitted our 2024 data in accordance with the National Committee for Quality Assurance (NCQA) reporting requirements.

We want to thank staff members who provided medical records in support of our HEDIS efforts.

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

Medicare Part B drug reminders

Read more about our prior authorization (PA) criteria and how to submit requests electronically.

A lot has changed in the Medicare Part B drug space over the past five years. From the implementation of step therapy to new Centers for Medicare & Medicaid Services (CMS) rules and regulations around Part B Utilization Management to frequent Healthcare Common Procedure Coding System (HCPCS) updates, there has been a lot to keep track of.

You can keep it all straight by visiting our **Part B drug utilization management page.** This is where you can find the preferred drug lists (PDLs) for our Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) members, our PA criteria, our step therapy criteria and our fax forms for PA requests. Alternatively, you can also use our **provider portal on Availity*** to submit PA requests for Part B drugs.

You're expected to follow our preferred drug lists when clinically appropriate for our members. Using office-specific formularies and electing to only stock non-preferred products aren't valid exceptions to step therapy. You can find each drug-specific step criteria document on our Part B drug utilization management page in the **Coverage Criteria Lookup**.

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

Change to Turnaround time (TAT) for Medicare standard organization determinations

The Centers for Medicare & Medicaid Services (CMS) is changing the TAT for standard organization determinations.

Effective January 1, 2026, CMS is changing the TAT for standard precertification requests (organization determinations) from 14 calendar days to 7 calendar days.

Reason for the change

The reason for the change in TAT is to significantly reduce delays in patient access to care by requiring payers to provide decisions within a shorter timeframe. The aim is to improve the health care experience for patients and alleviate burdens on you by streamlining the process and minimizing administrative work associated with waiting for approvals. We support the CMS change to promote timely access to care and to streamline administrative work for you.

What we'll need from you

For all standard organization determinations, we need clinical information to support the request for procedures/services.

Submit clinical information via the provider portal with the initial request or within three calendar days from the date requested so that we can make organization determinations timely and accurately.

Note: Expedited organization determination timeframes (72 hours) aren't changing.

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