September 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

Billing guidance reminder for HIV Preexposure Prophylaxis (PrEP)

When you bill for HIV PrEP-related tests, services and medications, avoid the general administrative code 96372.

Enhance patient care with biosimilars

As valued leaders in patient care, you have a powerful impact on our health care industry — not only on individual health outcomes but also on advancing accessible, sustainable health care for all.

TABLE OF CONTENTS

Important policy updates (including pharmacy)

Payment and coding

- Claim and Code Review update
- Changes to our National Precertification List
- Florida: New pre-approval requirements

Pharmacy and formulary

- Changes to commercial drug lists
- Important pharmacy updates

State-specific updates

The following article applies to Arizona, California, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Missouri, Nevada, New Jersey, North Carolina, Ohio, Texas, Utah and Virgina:

[ACA and QHP health exchange participation update]

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

[Reminder: VCC form required for Medicare C-SNP]

Florida

[New pre-approval requirements]

Illinois

[How we communicate contractual changes]

North Carolina

[North Carolina State Health Plan CPP is ending]

Massachusetts

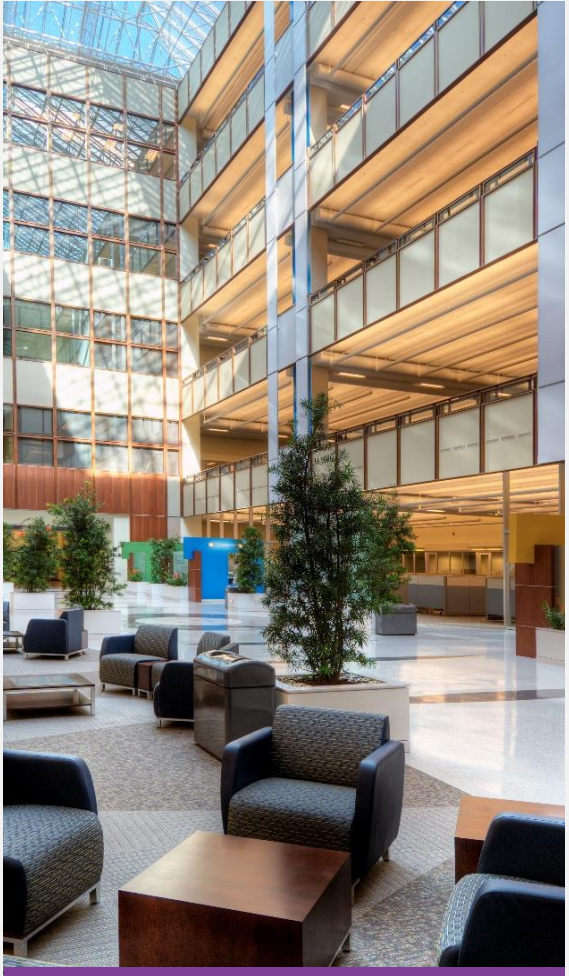
[Make sure your profile information is up to date]

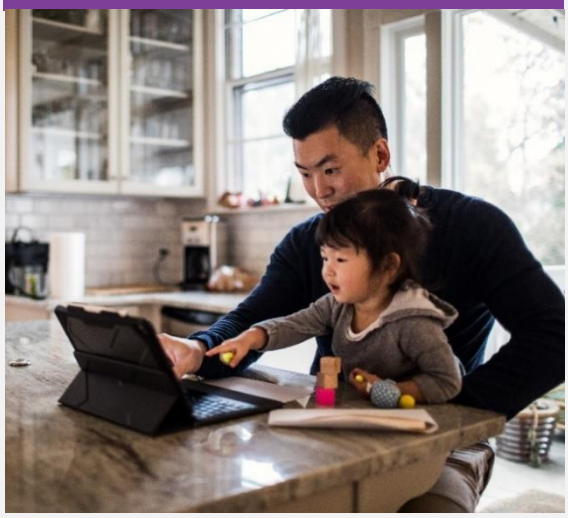
Pennsylvania

[PEBTF awards Aetna® exclusive medical administration]

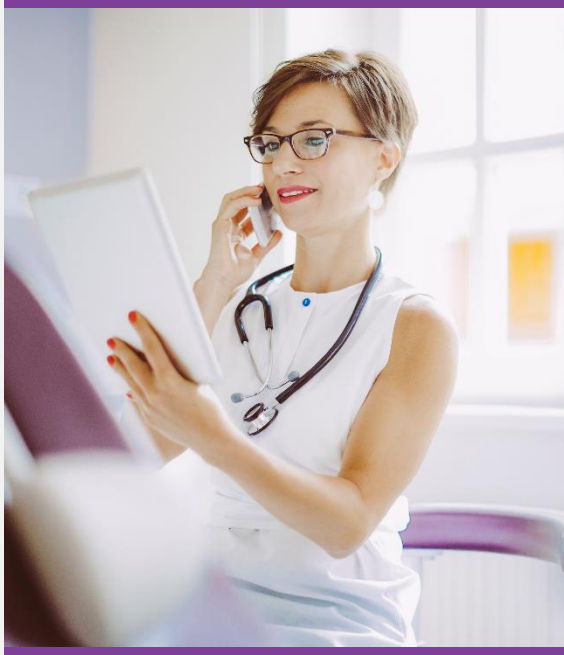
Washington

[Moda Health Plan, Inc. adds members]





News for you



Billing

[Billing guidance reminder for HIV PrEP]

Education and onboarding

[New provider onboarding webinar]

Patient experience

[Training that transforms: Meet PatientForward™]

Pharmacy management/formulary

[Enhance patient care with biosimilars]
[Weight-loss management]

Policy and practice updates

[2026 Aetna Smart Compare™]
[Informed Choice for members]
[Prepayment DRG claim review process]

Precertification, claims, referrals

[Auxiant increases membership with us]

Quality management

[Keep your demographic information up to date]
[Our office manual keeps you informed]

Standards, guidelines and documentation

[Our annual transition to the new edition of the MCG]

Behavioral health

Depression screening and suicide prevention

- SafeSide Framework for suicide prevention

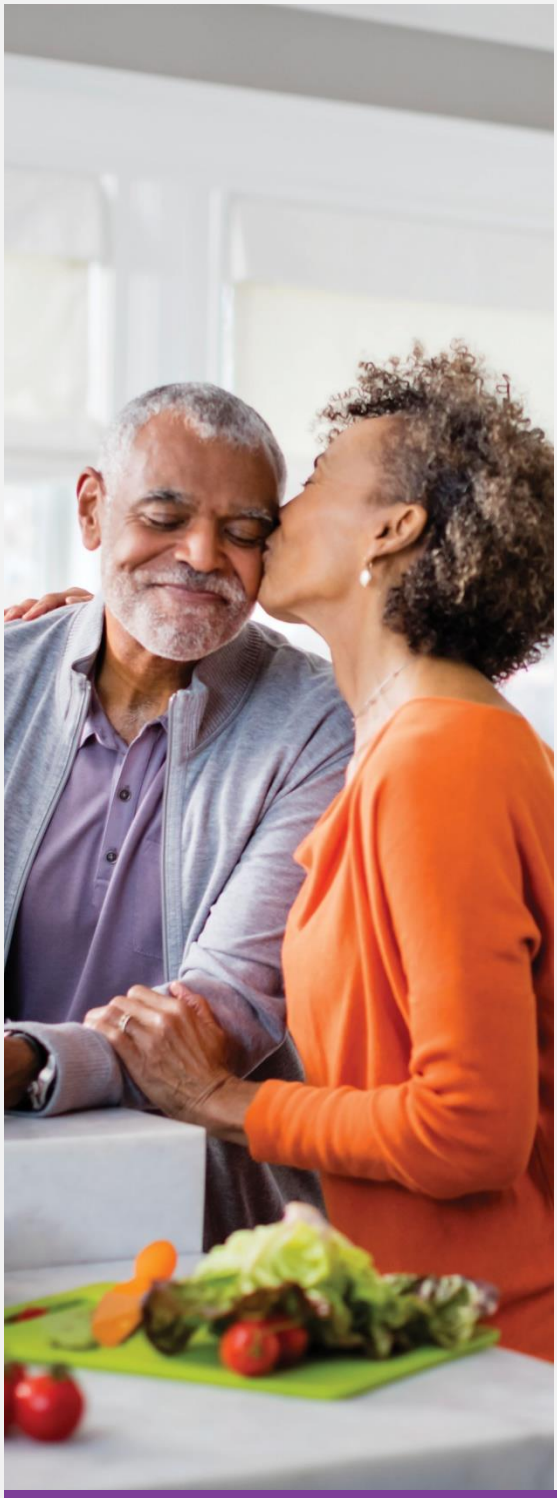
Guidelines, standards and criteria

- ABA medical necessity guide updates
- 2025 BH quality management program summary

Medicare

Compliance training

[Complete your Medicare attestation by October 31]



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 might see new claim edits.

This update applies to both our commercial and Medicare members.

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

Beginning December 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.

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

**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 outlined in this article.

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

Changes to our National Precertification List (NPL)

These changes apply to our commercial and Medicare members, unless otherwise noted.

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

- Electrophysiological (EP) study (93654)
- Yondelis® (trabectedin, J9352)
- Docivyx™ (docetaxel, J9172) — Medicare members only

Florida: New pre-approval requirements

Find out which services require pre-approval and how to send requests to Evolent.

This article applies to Florida members in Aetna® Medicare Advantage (MA) HMO/PPO products.

The Aetna Oncology Quality Management program will require authorization for certain procedures beginning January 1, 2026.

Services that require pre-approval

Oncology-related (medical and radiation oncology) infused and injectable chemotherapeutic agents, supportive/symptom management medications, and radiation treatment services administered in a physician's office, outpatient hospital, or ambulatory setting will be submitted to Evolent for prior authorization review for members 18 years of age and older.

The Evolent partnership will also include:

- Real-time authorizations for approvable treatment plans submitted via the **Evolent online portal**
- Confirmation of member eligibility through the Evolent portal prior to starting a treatment plan
- Oncology and radiation oncology clinicians on staff to answer your questions
- Telephonic intake for submitting treatment plans, if needed
- A dedicated Evolent Provider Performance Advisor to use as a direct point of contact for any issues or questions

Authorization requests

Board-certified Evolent physicians need to review authorization requests for medical necessity. To get paid for services, you must send authorization requests before providing services.

If treatment starts before January 1, 2026, contact Evolent to request continuity-of-care authorization. This will allow for consideration of claims for dates of service after January 1, 2026.

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

How to secure an authorization

You can submit medication or radiation oncology treatment requests by:

- Logging into the **Evolent provider web portal**
- Calling the Evolent Utilization Management Intake department Monday through Saturday, 8 AM to 8 PM ET, at **1-888-999-7713**. Select option 2 for medical oncology and option 3 for radiation oncology. Calls received after hours, weekends and holidays will be routed to Evolent via on-call services.

If you're unable to register online or if you need other assistance, you can:

- Call your Evolent Network Operations Representative
- Call Network Operations at **1-888-999-7713**, option 6
- **Email Evolent**

Urgent requests

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

What you should know

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

Questions

If you have questions, refer to our **Contact Aetna** page. Choose the Providers tab.

Visit Evolent to review criteria.

Changes to commercial drug lists begin on January 1

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

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

You'll be able to view the changes as early as October 1, 2025. 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, 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.

Important pharmacy updates

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

Medicare Advantage Prescription Drug Plan (MAPD) and Medicare Advantage (MA) member change

We added Roche, a manufacturer of Accu-Check Guide Me and Guide blood glucose meters and test strips, as a second preferred supplier.

Biosimilar additions to Medicare plan formularies

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.

- As of July 1, 2025, Yesintek and Pyzchiva (interchangeable biosimilars) were added to all formularies for Part D. Stelara will continue to remain on all formularies.

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

Commercial — notice of changes to 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.

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

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

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

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

Members currently enrolled in an Aetna CVS Health, Banner|Aetna or Innovation Health exchange plan (identified by a "QHP" in the upper-right corner of their ID card) will transition to alternative coverage effective January 1, 2026.

For additional details and answers to common questions, please refer to our **Provider FAQs**.

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

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

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

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

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

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

C-SNP enrollment is a two-step process

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

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

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

  We send the VCC form to the provider listed on the application. If we don't receive the completed VCC form documenting the member's qualifying condition within 30 days of enrollment, the member will be involuntarily disenrolled at the end of the second month.

How to access and submit the VCC form

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

- Our **provider portal on Availity**. Go to Aetna Payer Spaces > Resources. In the search bar, search for "VCC."
- Our **Forms for health care professionals** page on Aetna.com. Select "Chronic Condition Special Needs Plans (C-SNPs): Enrollment Verification" from the drop-down menu.
- **VCC form (PDF)**

Florida: New pre-approval requirements

Find out which services require pre-approval and how to send requests to Evolent.

This article applies to Florida members in Aetna® Medicare Advantage (MA) HMO/PPO products.

The Aetna Oncology Quality Management program will require authorization for certain procedures beginning January 1, 2026.

Services that require pre-approval

Oncology-related (medical and radiation oncology) infused and injectable chemotherapeutic agents, supportive/symptom management medications, and radiation treatment services administered in a physician's office, outpatient hospital, or ambulatory setting will be submitted to Evolent for prior authorization review for members 18 years of age and older.

The Evolent partnership will also include:

- Real-time authorizations for approvable treatment plans submitted via the **Evolent online portal**
- Confirmation of member eligibility through the Evolent portal prior to starting a treatment plan
- Oncology and radiation oncology clinicians on staff to answer your questions
- Telephonic intake for submitting treatment plans, if needed
- A dedicated Evolent Provider Performance Advisor to use as a direct point of contact for any issues or questions

Authorization requests

Board-certified Evolent physicians need to review authorization requests for medical necessity. To get paid for services, you must send authorization requests before providing services.

If treatment starts before January 1, 2026, contact Evolent to request continuity-of-care authorization. This will allow for consideration of claims for dates of service after January 1, 2026.

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

How to secure an authorization

You can submit medication or radiation oncology treatment requests by:

- Logging into the **Evolent provider web portal**
- Calling the Evolent Utilization Management Intake department Monday through Saturday, 8 AM to 8 PM ET, at **1-888-999-7713**. Select option 2 for medical oncology and option 3 for radiation oncology. Calls received after hours, weekends and holidays will be routed to Evolent via on-call services.

If you're unable to register online or if you need other assistance, you can:

- Call your Evolent Network Operations Representative
- Call Network Operations at **1-888-999-7713**, option 6
- **Email Evolent**

Urgent requests

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

What you should know

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

Questions

If you have questions, refer to our **Contact Aetna** page. Choose the Providers tab.

Visit Evolent to review criteria.

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

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 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:

- 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 information 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.

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

The North Carolina State Health Plan Clear Pricing Project (CPP) is ending

The State Health Plan is ending the CPP on December 31, 2025, but you could still be in network.

Beginning January 1, 2026, if you're a participating provider in the Aetna Choice® POS II network, you'll continue to be in network for the State Health Plan and will be reimbursed at your Aetna® contract rates.

New Behavioral Health Access Program (BHAP)

The State Health Plan is committed to continuing its effort to promote affordable access to behavioral health services through reimbursement rates and member cost-share. BHAP is a custom fee schedule for behavioral health providers. Unlike CPP, there are no copay differentials for BHAP providers.

Learn more about BHAP and sign up.

New programs for primary care physicians (PCPs)

The State Health Plan continues to value PCPs and will be rolling out new programs to support independent primary care. Visit the **North Carolina State Health Plan page** for more information about these efforts.

Questions?

You can:

- Call us at **1-800-353-1232** **(TTY: 711)** during normal business hours or **email our local network management staff**.

Massachusetts: Make sure your profile information is up to date

You're required to update your data across our provider directories, including the new expanded data fields.

Accurate and timely reporting helps members find you. Make sure that your information is correct and available to them when they need care.

Update your data

Here's how:

- Update your data on **Aetna.com**.
- If you're already registered for our **provider portal on Availity**,* you can update your data there.
- If you're new to Availity®, you can register to set up your account then update your data.

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

The Pennsylvania Employees Benefit Trust Fund (PEBTF) awards Aetna® exclusive medical administration

Effective January 1, 2026, the PEBTF has selected us as their exclusive commercial medical carrier for their active and early retiree members.

We'll be the sole administrator for all PEBTF medical plans in all counties across the Commonwealth. Additional information will be distributed closer to the effective date.

Washington: Moda Health Plan, Inc., an Aetna Signature Administrators® (ASA) third-party administrator, adds members

Moda Health Plan, Inc. has increased members accessing the ASA preferred provider organization program and medical network in Northern Washington.

How to check eligibility and get additional support

To check eligibility or verify benefits for Moda Health Plan members, use the Moda Health Customer Service phone number on the member's ID card.

How to send claims

Moda handles all claims processing and claims questions. Send claims electronically to Moda Health Plan EDI #13350. You'll also find this number on the member's ID card.

Or send paper claims to:

Medical Claims
P.O. Box 40384

Portland, OR 97240

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)**.

News for you

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

Billing guidance reminder for HIV Preexposure Prophylaxis (PrEP)

Make sure you're using the correct codes when billing for HIV PrEP-related tests, services and medications.

When you bill for HIV PrEP-related tests, services and medications, avoid the general administrative code 96372. Instead, use the following CPT®/HCPCS codes* in conjunction with the appropriate ICD-10 codes. You can also find this information on our **provider portal on Availity**.**

HIV PrEP-related tests, services and medications

- This **U.S. Preventive Services Task Force (USPSTF) recommendation** applies to persons who aren't infected with HIV and are at high risk of HIV infection.
- The Centers for Disease Control and Prevention (CDC) provides a complete discussion of implementation considerations for PrEP, including baseline and follow-up testing and monitoring, time to achieving protection and discontinuing PrEP.

Preventive coverage category	Associated CPT/HCPCS code(s)	Covered preventive diagnoses
Creatinine	82565, 82575	ICD-10 Codes considered preventive for this category:

		Z20.2, Z20.5, Z20.6, Z79.899
Glucose	82945	
Metabolic panels (includes creatinine)	80047, 80048, 80053	
Phosphorous	84100	
Protein	84156	
Protein and Creatinine	82570	
Urinalysis	81000-81003, 81005	
HIV screening	87536	ICD-10 Codes considered preventive for this category: Z11.3, Z11.4, Z11.59, Z20.2, Z20.5, Z20.6, Z29.81, Z72.51-Z72.53, Z79.899
	86701, 86702, 86703, 86689, 87389, 87390, 87391, 87806, G0432, G0433, G0435, G0475, S3645,	Covered as preventive for any diagnosis
Hepatitis B screening	86704, 86706, 87340, 87341, G0499	Covered as preventive for any diagnosis
Hepatitis C screening	86803, 86804, G0472	Covered as preventive for any diagnosis
Other sexually transmitted infection (STI) screenings • Chlamydia, gonorrhea, syphilis	Refer to Screenings section for all covered diagnoses, and the Testing section for all covered diagnoses.	
Adherence counseling	99401-99404, 99411-99412, G0013 and G0011	ICD-10 Codes considered preventive for this category: F19.10, F19.20, Z11.3, Z11.4, Z20.2, Z20.6, Z29.81, Z72.51-Z72.53, Z72.89
Office visit	99202- 99205, 99211 -99215, 99417, G0463	
Pregnancy test	81025, 84702, 84703	

Medications	J0739, J0741, J0750 and J0751	ICD-10 Codes considered preventive for this category: F19.10, F19.20, Z11.3, Z11.4, Z20.2, Z20.6, Z29.81, Z72.51-Z72.53, Z72.89, Z79.899
Supply/Administration	Q0521, G0012	ICD-10 Codes considered preventive for this category: F19.10, F19.20, Z11.3, Z11.4, Z20.2, Z20.6, Z29.81, Z72.51-Z72.53, Z72.89, Z79.899

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

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 polices
- 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 PM ET.

Questions?

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

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

Training that transforms: Meet PatientForward™

We're proud to launch the PatientForward™ platform — a cutting-edge digital learning environment created to support health care professionals in delivering exceptional patient experiences.

A platform with purpose

PatientForward is more than a training tool — it's a movement. Built to support practices of all sizes and specialties, this platform offers a structured, engaging and accessible way to elevate patient care. Whether your team is just beginning its patient experience journey or looking to strengthen its skills, PatientForward meets you where you are, in your own space and at your own pace.

What's inside?

Through story-driven video lessons that bring patient experience to life, AI-powered simulations and coaching for real-world practice, and live huddle resources to support team collaboration, the platform is delivered in stages, each with bite-sized lessons and powerful tools. Upon the completion of the program, learners receive digital badges via Credly to recognize and celebrate their growth.

Who should participate?

PatientForward offers flexible, role-specific learning that empowers every member of your team to grow, engage and elevate the care experience. Ideal for: providers (physicians, NPs, PAs), clinical teams (nurses, MAs, techs) and service teams (receptionists, schedulers, managers).

Explore the platform and partner with us

Take the first step toward more meaningful, impactful care by exploring the **PatientForward platform** today. As part of our ongoing commitment to enhancing the member experience and supporting our provider partners, we're providing these complementary innovative learning resources to our Medicare provider network — because **healthier happens together®**.

Enhance patient care with biosimilars

Choosing biosimilars helps reduce treatment costs, minimize access barriers, enable the reallocation of savings and more.

As valued leaders in patient care, you have a powerful impact on our health care industry — not only on individual health outcomes but also on advancing accessible, sustainable health care for all.

Why biosimilars matter

You can make an even greater difference by prescribing biosimilars. These FDA-approved alternatives are clinically equivalent to their reference biologics and offer the same safety and efficacy standards, supported by extensive clinical research and real-world use across diverse patient populations.

Why choose biosimilars

By choosing biosimilars when clinically appropriate, you:

- Help reduce treatment costs
- Minimize access barriers
- Optimize the use of health care resources by increasing patient access to safe and effective treatments at a lower cost
- Reduce reliance on high-cost reference biologics
- Enable the reallocation of savings toward other critical areas of patient care — all without compromising the quality of care your patients receive

Support and resources

We recognize that biosimilar adoption is also influenced by state-level policy. While we continue to advocate for broader state preferencing of biosimilars, we're here to support you with the latest:

- Formulary information
- Clinical data
- Tools to make the transition as smooth as possible

Find out whether your state supports biosimilar adoption.

Weight-loss management

Resources to support you and your patients due to recent coverage changes.

As of July 1, 2025, we changed how or whether we covered certain weight-loss medications,

including Zepbound. Because these changes could affect how your patients get weight-loss help, we'd like to refer you to relevant resources.

Coverage details

Our **pharmacy CPBs** and **medical CPBs** outline coverage details, including covered bariatric surgeries and the clinical criteria for weight-loss medications.

See these in particular:

- **Obesity Surgery**
- **Weight reduction programs and devices**

Weight-loss medication coverage

- **Wegovy**
- **Saxenda**

State-specific mandated coverage: (California and New York)

- **Anti-obesity agents**

2026 Aetna Smart Compare™ is coming soon

Evaluation notifications will begin in late 2025.

The Aetna Smart Compare program

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

Evaluation notification

In late 2025, we'll notify the physicians we've evaluated. These physicians can go to our **Aetna Smart Compare Designation** page and refer to the Aetna Smart Compare Methodology Guide to access the latest standards and measurements applicable to the evaluation period.

Evaluation period for 2026

The 2026 designations for Aetna Smart Compare evaluate claims data from 2023 and 2024.

How to dispute a designation

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

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

We're launching Informed Choice for members

Informed Choice will make use of our Aetna Smart Compare™ program.

We'll soon launch a new product we're calling "Informed Choice." This product will make use of our Aetna Smart Compare program, which measures cost and quality across several specialties. Informed Choice, which is designed to enhance current benefits without affecting participation in networks, will be available to the commercial group business in 2026.

Lower copayments for members

Members enrolled in Informed Choice might have lower copayments if they choose physicians designated in Aetna Smart Compare. And if members receive care from orthopedic surgeons designated in Aetna Smart Compare, their inpatient and outpatient surgery copayments for knee, hip and shoulder replacements could be lower.

Smart Compare designated providers are identified with a "quality & effective care" badge in our provider search.

Physician specialties included

Aetna Smart Compare currently measures physicians under these specialty programs: allergy/immunology, behavioral health — psychiatry, cardiology, cardiothoracic surgery, dermatology, endocrinology, gastroenterology, general surgery, medical oncology, neurology, neurosurgery, nephrology, OB/GYN, orthopedic surgery, otolaryngology, primary care physician (PCP), plastic surgery, pulmonology, rheumatology, urology and vascular surgery.

Informed Choice creates lower copayments for all of these specialties, except medical oncology.

More information

You can learn more about Aetna Smart Compare by visiting **our Smart Compare page**.

Prepayment diagnosis-related group (DRG) claim review process

Our review process ensures your claim diagnosis and procedure code information is accurate.

We do prepayment claim reviews for specific DRG claims to improve the accuracy of our DRG payments. Through our review process, we ensure that your claim diagnosis and procedure code information is accurate based on the patient's medical record.

More on our review process

- We use clinical criteria to approve admissions and ongoing inpatient hospital stays.
- For DRG facilities, we review diagnosis codes, procedure codes and other related clinical information obtained during the care management review process.
- If we don't have access to the electronic medical record (EMR) and we find that the DRG billed doesn't match the diagnosis codes/procedure codes in the clinical information available, we'll request additional records. To find out how to use the EMR with us, reach out to your network representative.
- When we need records, you'll receive a detailed letter requesting additional medical records and explaining why we need them. If we don't receive the records within the stated timeframe, we'll process the claim using the DRG information provided in the letter.

Helpful tips

To make sure we review your claims quickly and correctly, we'll need all the right clinical information up front:

- Work with our Care Management team to provide comprehensive clinical information relevant to the inpatient admission.
- Check that the International Classification of Diseases (ICD) diagnosis and procedure codes, as well as the services rendered, support the billed DRG.
- If we ask for additional medical records, return them within the referenced timeframe. You can send paper copies to the address provided, fax to the number on the letter or upload medical records electronically via our **provider portal on Availity**.*
- For more insight on our prepayment DRG reviews, ask your network representative for our case studies document. This document provides examples of reviews for a

variety of conditions, including but not limited to anemia, heart failure, sepsis and respiratory failure.

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

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.

Auxiant, an Aetna Signature Administrators® (ASA) third-party administrator, increases membership with us

Auxiant membership has more than doubled since they started using ASA to access the Aetna® preferred provider organization (PPO) network.

Auxiant has expanded their reach to include plan sponsors in Texas, Michigan, Virginia and California.

How to recognize an ASA and Auxiant member

The member ID card will have both the Auxiant and Aetna logo, as well as a reference to the ASA solution. There may be additional logos when the member lives in a rental or rural network area.

How to check eligibility and get additional support

Call Auxiant at **1-800-279-7662** to check eligibility, confirm benefits and check claim status.

How to send claims

Our TPA partners handle all claims processing and claims questions. Send claims electronically to Auxiant's payer ID, which is listed on the member's ID card.

Or send paper claims to:

Auxiant
P.O. Box 0392
Milwaukee, WI 53201-0392

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)**.

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**.

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

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 disease management, the Aetna Enhanced Maternity Program, Healthy Lifestyle 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.

Our annual transition to the new edition of the MCG

We use evidence-based clinical guidelines from nationally recognized authorities, such as MCG, to make utilization management (UM) decisions.

Every year, we coordinate with MCG to update to their new edition. On May 3, 2025, we started using the 29th edition of the MCG and will use it for designated reviews.

Behavioral health

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

SafeSide Framework for suicide prevention in primary care

We're excited to offer a no-cost suicide prevention interactive, virtual workshop.*

This upcoming workshop will help you understand how to identify patients at risk of suicide. **Join us** Wednesday, September 17, 2025, from 12:00 to 3:30 PM (ET) via Zoom.

Seats are limited, and this special event will not be recorded to protect privacy and encourage participation.

Here's what we'll cover

In the workshop you'll learn how to:

- **Connect** — ask directly and clearly about suicide without losing your connection with a patient.
- **Assess** — use a consistent structure for gathering and communicating information.
- **Respond** — make initial plans for how the patient and others will respond to foreseeable changes that might increase risk.
- **Extend** — employ the suicide related warm handoff.

In addition to this learning opportunity, you'll benefit from:

- Three AMA Category 1 CMS credits
- A one-year subscription to SafeSide Prevention which includes exclusive access to the library of resources, Community of Practice (a global network sharing insights and experiences) and monthly office hours.

*Behavioral health clinicians housed in a primary care practice are welcome to register.

Applied Behavior Analysis (ABA) medical necessity guide updates

We'll release the new edition of the **ABA medical necessity guide** on September 1, 2025. It contains changes to the criteria required to initiate and continue applied behavioral analysis.

2025 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 care we provide to our members.

Highlights from 2024

- Our behavioral health quality management team collaborated with our data reporting and BH network teams to present the annual BH Availability and Accessibility analyses to our quality oversight committee. The Accessibility analysis demonstrated improvement in access to care.
- In October 2024, we launched Aetna 360™ Behavioral Health Facility surveys, which closed on November 16, 2024. The program received a 100% overall satisfaction score and an 88 net promoter score (NPS).
- Medicare Advantage complex case management (CCM) was refined for enhanced risk assessment and safety planning, to align with the enterprise suicide prevention strategy.
- As of October 30, 2024, based on completed claims data, there had been a 21.6% decrease in suicide attempts among our commercially insured adult members when compared to the same period for the 2019 baseline year. For comparison, the Centers for Disease Control and Prevention (CDC) cited a decrease in suicide rates in 2019 and 2023; the numbers increased 4% in 2021 and 3% further in 2022, which was the highest number on record.
- Our LGBT Responsive Care Champion Badge Program was discussed in an article written by Dr. Deborah Fernandez-Turner, Aetna Deputy Psychiatric Officer and Jordan Pritzker, Aetna Mental and Emotional Health Medical Director. This article was published in a blog for the New England Employee Benefits Council and discusses our support of members through the provision of gender affirming care and through helping our providers practice the most evidence based and supportive care possible. You can earn the LGBT Responsive Care Champion Badge by taking a set of free trainings that result in a cultural competency certification. You'll then have a badge displayed next to your information in our provider search tool.
- CVS Health® virtual care provides scheduled mental health services to our commercial members nationwide who are enrolled in eligible fully insured and self-insured health plans. As of December 2024, 85,000 visits were completed with the majority being Aetna and Resources for Living members; over 75% of patients reported symptom reduction. Members ages 18 and older enrolled in the program have access to virtual mental health support nationwide, seven days a week from providers, including licensed therapists and psychiatrists.
- Behavioral health commercial plans saw an improvement in Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7) scores were improved from baseline to repeat assessment by 32.28% during participation in Complex Case Management.

Plans for 2025

- Improve network adequacy; focusing on geographic/numeric availability of behavioral health providers and appointment timeliness in markets which fell below goal in 2024.

- Administer paired PHQ-9 and GAD-7 assessments to commercial and Medicare members enrolled in case management who score a 10 or more on initial assessment, at a rate of 40% or more.
- Drive population focused clinical initiatives to enable test and learn innovation pilots for youth, older adults, people with substance use disorders and those at risk for suicide.
- Expand MinuteClinic® services to include the treatment of adolescents ages 13 and up, across all states where services are offered. Additionally, optimize Aetna Health search and visibility in the provider directory of MinuteClinic behavioral health providers to better engage our members.
- Focus on behavioral health network expansion with the goals of increasing provider availability and reducing appointment wait times.
- Continue to use and refine predictive modeling to proactively identify members who may benefit from Medicare Behavioral Health Case Management.
- Continue to administer member and caregiver case management satisfaction surveys to members who have completed engagement with behavioral health case management, with the goals of adapting programs to better meet member needs and achieve a net promoter score of >65.
- Continue to develop robotics expertise and work towards the creation of automated solutions to reduce manual work and data entry.
- Implement the 2025 suicide prevention roadmap to meet or exceed our bold goal for suicide prevention. Improve adolescent suicide prevention outcomes.
- Improve quality of care, achieve strong clinical outcomes and drive patient safety.
- Promote care coordination between medical and behavioral health providers. (The care coordination article is on page 45 of our **March 2025 quarterly edition of OLU**).

More information

Find more resources on **our behavioral health member site**.

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

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 received a training and attestation notice to the compliance email(s) submitted with their 2024 attestation. If we didn't have your email address (or the email was undeliverable), a postcard reminder to complete your attestation (and MOC training, if applicable) was mailed during the summer.

How to submit your attestation

If you did not receive a notice or have not completed your required training(s), please visit the **Medicare compliance and attestation** page to review the materials and submit your attestation.

Training materials

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

Attestations based on contracted plans

Providers:

- MA/MMP: **Complete MA 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**.