

Subject: **Aetna monthly OfficeLink Updates, November 2026 – policy changes and updates**

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Preview Text: **Learn about important policy updates, material changes and amendments**

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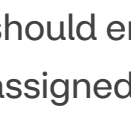


November 2026

This month's policy changes and reminders

We regularly review and adjust our clinical, payment and coding policies. Review our policies and claim edits on our provider portal on Availity®.* Just go to **Payer Space > Resources > Expanded Claim Edits.**

Policy changes



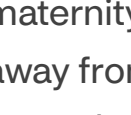
Medicare MoIDX claims processing enhancements

To support future Medicare MoIDX claims processing enhancements, providers and laboratories submitting molecular diagnostic testing claims in MoIDX jurisdictions should ensure that applicable tests are registered and assigned a DEX® Z-Code® identifier.

Medicare MoIDX claims processing may require submission of the applicable DEX Z-Code along with the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT®/HCPCS) code for molecular diagnostic tests subject to MoIDX requirements.** The DEX Z-Code is a unique identifier that allows the specific molecular test performed to be identified and supports accurate claims adjudication.

What you should do

- Review your molecular diagnostic testing inventory and identify tests subject to MoIDX requirements.
- Ensure that applicable tests are registered in the DEX Diagnostics Exchange and have an assigned Z-Code.
- Update billing processes and systems to support reporting of Z-Codes on Medicare claims.



Upcoming changes to maternity care coding and reimbursement

This update applies to commercial and Medicare members.

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

What's changing?

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

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

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

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

What you should know

The AMA's CPT Editorial Panel approved:

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

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

Preventive and nonroutine prenatal and postpartum office visits

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

For these routine preventive visits:

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

Nonroutine prenatal and postpartum E/M office visits shouldn't be submitted with modifier TH and are subject to applicable member cost share.

Review the updated Routine Preventive Care Benefit Guidance statement on our [provider portal on Availity](#) for additional information.*

Billing prenatal visits during the transition to 2027

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

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

More information

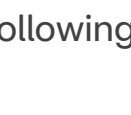
To support you during this transition, we've created a Maternity Coding Transition Resource on our [provider portal on Availity](#). We encourage you to review this resource regularly for the most current information.

Consult these AMA resources to help you understand upcoming changes:

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

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

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



Changes to our National Precertification List (NPL)

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

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

- Isemyld® (apitegromab-mstn) (J3490, J3590, C9399)
- Fayuvi® (rebisfligene etisparvovec-hopf) (J3490, J3590, C9399)

Effective January 1, 2027, we'll require precertification for the following drugs:

- Bexlutry® (lutetium Lu 177 dotatate) (J3490, J3590, C9399, J9999, A9699)
- Bravnetsa® (lutetium Lu 177 dotatate) (J3490, J3590, C9399, J9999, A9699)
- Aflibercept-boav (J3490, J3590, C9399, Q5170)

Effective January 1, 2027, we'll require precertification for both commercial and Medicare members, in addition to Site of Care for commercial, for the following drug:

- Degevma ® (denosumab-adet) (J3490, J3590, C9399)

Effective February 1, 2027, we'll require an additional Site of Care review for commercial. The following drug already requires precertification for commercial and Medicare.

- Signifor LAR® (pasireotide) (J2502)

Effective February 1, 2027, we'll require precertification for the following drug:

- Bendamustine hydrochloride (Avyxa) (J9066)

Effective February 1, 2027, we'll require precertification for commercial only for the following drug:

- Docetaxel (Hospira) (J9232)

Effective February 1, 2027, we'll require precertification for commercial. The following drug already requires precertification for Medicare.

- Kyxata® (carboplatin) (J9278)

Effective February 1, 2027, we'll require precertification for the following:

- Custom Microprocessor controlled Knee-Ankle-Foot Orthosis (KAFO) (L2006)

Submitting precertification requests

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

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

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

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.



Reminder: Observation Payment Policy follows CMS guidance for HCPCS code G0378

This applies to commercial and Medicare lines of business.

The Centers for Medicare & Medicaid Services (CMS) requires the number of units reported with G0378 to equal or exceed eight hours. When G0378 is billed for less than eight hours, the observation service isn't reimbursable. However, other eligible services may be reimbursed in accordance with your contract.

Please review your billing practices and ensure that observation services are submitted in accordance with these requirements.



You can always find this information on our provider portal on Availity.*

You can also use our Code Edit Lookup tools on Availity®. Just go to **Payer Space > Applications > Code Edit Lookup Tools**. Keep your Aetna® provider ID number handy to access them.

[Availity portal](#)

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