Name: October 2026 OLU provider newsletter
Subject: Aetna monthly OfficeLink Updates, October 2026 — policy changes and updates
Preheader: Learn about important policy updates, material changes and amendments

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October 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

Changes to medical plan drug lists

On January 1, 2027, we'll update our medical plan drug lists. These changes support our commitment to high-quality, cost-effective health care. Some of your patients may already be taking these drugs. If your patients have an existing authorization in place for the impacted drugs, this change won't affect them until their current authorization's expiration date.

Starting on November 1, 2026, we'll notify your impacted patients of these changes. We'll suggest that they talk to you about changing to a preferred alternative drug if appropriate.

You'll be able to view the changes online as early as November 1, 2026. They'll be posted on our **Precertification lists and medical preferred drug information page**.

No action required for current prior authorizations (PA)

If you're currently managing patients with a PA for a drug that moved to non-preferred status, you don't need to initiate the PA process again. Their current PA will remain in place until its expiration date.

Medical exceptions

If the patient needs to remain on the current medication through the remainder of their current PA, there's no medical exception needed.

Combined Benefit Management drug list changes

This information doesn't apply to Aetna Health Exchange and federal employee plans.

On January 1, 2027, we'll update the drugs covered on the Combined Benefit Management drug list. This list applies to certain specialty medications for our commercial fully insured members with Aetna® medical and pharmacy benefit plans, subject to applicable state laws.

With these updates, certain drugs may move from a member's medical benefit to their pharmacy benefit, or vice versa.

These updates support our commitment to high-quality, cost-effective health care.

What's behind the updates

The updates focus on drugs known as provider-administered specialty drugs.

Your patients may see lower costs for those drugs and may have the opportunity to enroll in copay assistance programs. Some of your patients may already be taking these drugs.

Supporting you and your patients

We'll notify patients affected by these changes. Beginning November 1, 2026, you can access these changes on our **Precertification lists and medical preferred drug information page**.

No action required for existing prior authorizations (PA)

We're committed to smooth transitions for you and your patients. PAs for members currently on an affected drug will remain in place until the current expiration. We'll proactively load a PA on the new benefit with the same termination date as the member's existing PA.

Your next steps

- Review your patients' current treatment plans and the drug list changes.
- If you're currently billing a drug to the medical benefit that's now moving to the pharmacy benefit, you may need to issue a prescription to an in-network specialty pharmacy. Or, if you determine it's clinically appropriate and choose to transition the patient to a preferred alternative drug option under the medical benefit, you'll need to submit a new PA.
- If you're currently accessing a drug through the patient's pharmacy benefit that's now moving to the medical benefit, you may continue to receive the drug from the in-network specialty pharmacy. The specialty pharmacy will change their billing from pharmacy to medical coverage.

Changes to our National Precertification List (NPL)

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

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

- Lytenava® (bevacizumab-vikg) (J3490, J3590, C9399)

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

- Tudriqev® (vusolimogene oderparepvec) (J3490, J3590, C9399)
- Genglycos® (pariglasgene brecaparvovec) (J3490, J3590, C9399)
- Pasatru® (garetosmab-grts) (J3490, J3590, C9399)
- Zanvastro® (zilganersen) (J3490, J3590, C9399)
- Elzonris® (Tagraxofusp) (J9269)

Effective October 1, 2026, we'll require Site of Care review for commercial and precertification for the following drugs:

- Zimrixby® (rituximab-cdxx) (J3490, J3590, C9399, J9999)
- Jobevne® (bevacizumab-nwgd) (Q5160)
- Avzivi® (bevacizumab-tnjn) (J3490, J3590, C9399, J9999)

Effective October 1, 2026, we'll no longer require precertification for commercial for the following drugs:

- OrthoVisc® (hyaluronan) (J7324)
- Zarxio® (filgrastim-sndz) (Q5101)
- Bortezomib® (Dr. Reddy's) (J9046)
- Bortezomib® (Hospira) (J9049)
- Fusilev® (levoleucovorin) (J0641)

Effective October 1, 2026, we'll no longer require precertification for Medicare for the following drugs:

- Bortezomib® (Velcade)(J9041)
- Bortezomib® (Dr. Reddy's) (J9046)
- Bortezomib® (Fresenius Kabi) (J9048)
- Bortezomib® (Hospira) (J9049)
- Fusilev® (levoleucovorin) (J0641)

Effective October 1, 2026, we'll no longer require Site of Care review for the following drugs (precertification will remain in place):

- Datroway® (datopotamab deruxtecan-dlnk) (J9011)
- Omisirge® (omidubicel) (J3490, J3590, J9999, C9399)

Effective January 1, 2027, we'll no longer require precertification for Medicare for the following drug:

- Nivestym® (filgrastim-aafi) (Q5110)

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

- Onivyde® (irinotecan liposome) (J9205)
- Nplate® (romiplostim) (J2802)
- Hepzato® (melphalan hydrochloride) (J9248)
- Blincyto® (blinatumomab) (J9039)
- Evomela® (melphalan hydrochloride) (J9246)
- Elitek® (rasburicase) (J2783)
- Oncaspar® (pegaspargase) (J9266)
- Rylaze® (asparaginase erwinia chrysanthemi (recombinant)-rywn) (J9021)
- iDose TR® (travoprost) (J7355)
- Avgemsi® (gemcitabine) (J9184)
- Koate® (antihemophilic factor [human]) (J7190)

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

- Vykoura® (leucovorin) (C9310)
- Frindovyx® (cyclophosphamide) (J9072)

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

- Gazyva® (obintuzumab) (J9301)

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

- Closure of congenital interatrial communication via percutaneous transcatheter (93580)

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.

Trauma response revenue code billing requirements

This update applies to both commercial and Medicare lines of business.

To support accurate billing and ensure alignment with trauma activation reimbursement requirements, we'll be implementing new claim editing for trauma response charges billed by facilities.

Effective January 1, 2027, we'll deny trauma response charges reported with revenue codes 0681–0684 unless both of the following items are billed on the same date of service (DOS):

- A paid HCPCS code G0390 (trauma response team associated with hospital critical care service) and
- A paid qualifying ambulance transport charge

We'll deny claims that don't meet both requirements.

Revenue codes impacted

The following trauma response revenue codes are subject to this edit:

- 0681: Trauma Response, Level I
- 0682: Trauma Response, Level II
- 0683: Trauma Response, Level III
- 0684: Trauma Response, Level IV

What this means for you

To receive reimbursement for trauma response charges, you must ensure that:

- Revenue code 0681, 0682, 0683 or 0684 is billed with a payable G0390 trauma activation code
- A qualifying ambulance transport service is billed and payable on the same date of service
- All services support the documented trauma activation event and meet applicable billing requirements

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 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.

Allograft rejection testing performed with biopsy procedures

This applies to Medicare lines of business.

Effective January 1, 2027, we'll be implementing updates to reimbursement for certain molecular allograft rejection tests when billed in conjunction with biopsy procedures.

These changes are intended to align reimbursement with coding and payment guidelines for services that are considered incidental to a biopsy procedure performed on the same date of service.

What's changing?

Heart transplant allograft rejection testing

Effective for dates of service on or after January 1, 2027, CPT® code** 81595 will be denied as incidental when billed on the same date of service as:

- 93505 — Endomyocardial biopsy

Kidney transplant allograft rejection testing

Effective for dates of service on or after January 1, 2027, CPT code 0540U will be denied as incidental when billed on the same date of service as any of the following biopsy procedures:

- 50200 — Kidney biopsy, percutaneous
- 50205 — Kidney biopsy, open
- 50542 — Laparoscopy, surgical; ablation of renal mass lesion(s)
- 93505 — Endomyocardial biopsy

Affected codes

- 81595: Cardiac allograft rejection gene expression profiling test
- 0540U: Kidney allograft rejection assessment test
- 93505: Endomyocardial biopsy
- 50200: Percutaneous kidney biopsy
- 50205: Open kidney biopsy
- 50542: Laparoscopic renal procedure

What this means for you

You should review billing practices and coding workflows to ensure that you submit claims in accordance with these reimbursement requirements.

Claim and Code Review Program (CCRP) update

This update applies to our commercial, Medicare and Student Health members.

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

Beginning January 1, 2027, you may see new claim edits.These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **provider portal on Availity**.*

For coding changes, go to Aetna Payer Spaces > Resources. In the search bar, search for “expanded claim edits.”

Except for Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to Availity®. You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

We may request medical records for certain claims, such as high-dollar claims, implant claims, anesthesia claims, and bundled services claims, to help confirm coding accuracy.

Note to Washington State providers: For commercial plans, your effective date for changes described in this article will be communicated to you following regulatory review.

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

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

Upcoming changes to maternity care coding and reimbursement

This update applies to commercial and Medicare members.

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

What's changing?

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

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

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

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

What you should know

The AMA's CPT Editorial Panel approved:

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

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

Preventive prenatal office visits

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

We encourage you to review the preventive prenatal office visit guidance available through our updated Routine Preventive Care Benefit Guidance statement on our **provider portal on Availity**.*

For patients expected to deliver in 2027, preventive prenatal visits on or after September 1, 2026, should be billed with the applicable ELM 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.

You should document and bill office visits for medical conditions or complications during the prenatal and postpartum periods based on the medical reason for the encounter. We encourage you to review updated maternity coding guidance before the 2027 implementation.

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 becomes 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.

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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